DOCUMENT RESUME

ED 325 559 UD 027 681

AUTHOR	Randall-David, Elizabeth
TITLE	Strategies for Working with Culturally Diverse Communities and Clients.
INSTITUTION	Association for the Care of Children's Health, Washington, DC.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Rockville, MD. Office for Maternal and Child Health Services.
REPORT NO	ISBN-0-937821-58-6
PUB DATE	Jun 89
CONTRACT	MCH-372004-03
NOTE	99p.
AVAILABLE FROM	Association for the Care of Children's Health, 3615 Wisconsin Avenue, N.W., Washington, DC 20016.
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Acquired Immune Deficiency Syndrome; Amish; Asian Americans; Blacks; *Counseling Techniques; *Cross Cultural Training; Cultural Awareness; Cultural Differences; *Cultural Traits; *Ethnic Groups; Haitians; Health Promotion; Hispanic Americans; *Intercultural Communication; *Medical Care Evaluation; Public Health
IDENTIFIERS	*Hemophilia

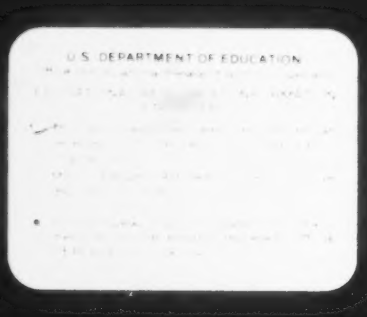
ABSTRACT

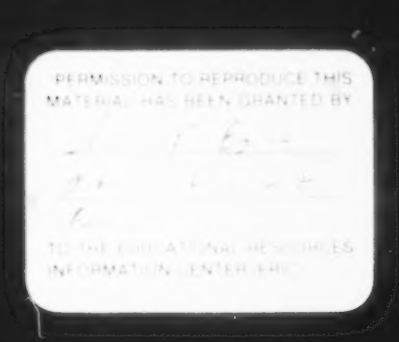
This guide, originally written to aid in the identification and education of ethnic minority patients with hemophilia, has been published to assist community groups in a range of educational, medical, and social service outreach efforts. It begins with two introductory chapters on ethnic identity and intergroup relations. Chapter 3 offers suggestions for learning about the target community. Chapter 4 contains guidelines for locating community groups and individual clients who require education, counseling, and/or treatment. Chapter 5 discusses the use of interpreters to enhance cross-cultural communication. Chapter 6 provides practical information on working with Amish persons, Asian Americans, Black Americans, Haitians, and Hispanics. A bibliography of 67 items follows. Appendix A contains a list of assessment questions to aid the user in understanding medical systems within different cultural contexts. Appendix B contains Bloch's Ethnic/Cultural Assessment Guide, an outline for interviewers. Appendix C is a list of names and addresses of organizations serving culturally diverse communities. (DM)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

Strategies for Working With Culturally Diverse Communities and Clients

Elizabeth Randall-David, Ph.D.





Prepared in conjunction with the
Comprehensive Hemophilia Program
Bowman Gray School of Medicine

with support from the
Hemophilia Program
Office of Maternal and Child Health
Bureau of Maternal and Child Health and Resources Development
U.S. Department of Health and Human Services

■ ■ ■

■ **The Hemophilia Program**, in keeping with the mission of the Office of Maternal and Child Health, U.S. Department of Health and Human Services, funds demonstration projects for National Hemophilia Foundation Chapters working with comprehensive treatment centers to improve outreach to culturally diverse populations.

For additional information, please contact:

Sharon Barrett
Director, Hemophilia Program
Office of Maternal and Child Health
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-2370

Published by:

■ **The Association for the Care of Children's Health** through the Family-Centered Care Grant, #MCH 113793, from the Bureau of Maternal and Child Health and Resources Development, U.S. Department of Health and Human Services.

The Association for the Care of Children's Health is a nonprofit organization that addresses the psychosocial and developmental issues in pediatric health care and seeks to promote the health and well-being of children and their families in health care settings. For further information on ACCH projects, publications and media, conferences, and consultation services assisting in the development of family-centered care policies and programs, please contact:

Association for the Care of Children's Health
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016
(202) 244-1801

This publication was developed under Grant #MCH 372004-03 from the Office of Maternal and Child Health. While contractors and grantees are encouraged to express freely their judgments on professional and technical matters, points of view do not necessarily represent those of the Department of Health and Human Services. This publication is presented for information purposes only, and no claims of accuracy are made. Mention of trade names, commercial products, or organizations does not constitute endorsement by the U.S. Government.

Strategies for Working With Culturally Diverse Communities and Clients

by
Elizabeth Randall-David, Ph.D.

1st Edition
June 1989

Published by the Association for the Care of Children's Health
3615 Wisconsin Avenue, N.W.
Washington, DC 20016

Copyright 1989, Association for the Care of Children's Health

International Standard Book Number 0-937821-58-6

Table of Contents

Preface v

Chapter 1: Setting the Stage 1
Some Working Definitions 1

Chapter 2: Assessing Your Own Cultural Heritage 5
Exercise 1: Acknowledging Your Cultural Heritage 5
Exercise 2: Exploring Specific Cultural Attitudes 6
Exercise 3: How Do You Relate to Various Groups of People in the Society? 7
Exercise 4: Getting in Touch with Your Own Social Identity 10
Exercise 5: White/Black Interpersonal Relations 12

Chapter 3: Learning About the Community 15
Conducting a Community Assessment 15

Chapter 4: Guidelines for Working With Culturally Diverse Community Groups and Clients 19
Identifying Clients 21
Education 22
Counseling 24
Treatment 27

Chapter 5: Guidelines for Using Interpreters to Enhance Cross-Cultural Communication 31
How to Choose an Interpreter 31
How to Work with an Interpreter 32
Nonverbal Communication 33

Chapter 6: Relevant Information on Specific Cultural Groups 35
Amish 35
Asian Americans 40
Black Americans 48
Haitians 52
Hispanics/Latinos 55

Bibliography 61

Appendices

Appendix A: Guidelines for Analysis of Sociocultural Factors in Health 69

Appendix B: Bloch's Ethnic/Cultural Assessment Guide 85

Appendix C: Organizations Serving Culturally Diverse Communities 95

Preface

The Community Outreach Demonstration Project (CODP) was initiated, guided, and funded by the Department of Health and Human Services, Office of Maternal and Child Health (OMCH), under the direction of Sharon Barrett, Director, Hemophilia Program. The major goal of the project is the identification of ethnic minority patients with hemophilia in order to provide this often difficult-to-reach population with relevant education and comprehensive hemophilia treatment. Through a collaborative relationship with the National Hemophilia Foundation (NHF), OMCH has been instrumental in providing training and technical assistance to local NHF chapters involved with outreach to culturally diverse communities and clients.

Although this manual was originally designed to guide project participants, most of the principles can be effectively utilized by a variety of community groups engaged in a broad range of educational, medical and social service outreach efforts. It is hoped that these principles will be applicable for working with families caring for children with a variety of chronic illnesses and disabilities. It is also hoped that an increased awareness of the importance culture plays in shaping our attitudes, values, and practices will lead to more culturally appropriate community outreach and culturally sensitive health care.

Members of the Community Outreach Demonstration Project Task Force who provided technical assistance throughout the project and who reviewed and critiqued earlier drafts of this manual include: Lisa Flam, M.P.H.; Claire Garceau; Donald Goldman, Esq.; Mary Gooley; Natalie Sanders, M.D.; Jeanette Stehr-Green, M.D.; Ashaki Taha; Mirielle Tribie, M.D.; and Ron Walker, Ph.D. In addition, Sharlene Simpson, Ph.D., and Manny Laureano-Vega, M.D., offered greatly appreciated input and critical comments. A special thanks goes to each of them for their willingness to share their expertise and individual perspectives. April Mackenzie and Sara Jarvis provided assistance with the technical aspects of typing and assembling the manual. And, finally, we gratefully acknowledge Christine Johnson, M.D., for providing a funding mechanism through the OMCH Region IV Hemophilia Grant for completion of this manual. Truly this project is a team effort.

Betsy Randall-David, Ph.D.

Setting the Stage

> *In the history of human thinking, the most fruitful developments frequently occur at those points where different lines of thought meet. These lines may have their roots in different cultures, in different times, in different religious traditions. If these are allowed to meet . . . a new and interesting way of being will emerge.* (Heisenberg, 1974)

Like a quilt rich in colors, textures, and patterns, the United States is a nation made up of many ethnic, racial, religious, and cultural groups. The concept of the melting pot, now outmoded, has been replaced by the recognition that this diversity lends strength and uniqueness to the fabric of our society. With the broad range of experience that the various parts of our population bring to everyday life in America comes the need for increased efforts at understanding and valuing our differences as well as our similarities. Since the culture in which we are raised greatly influences our attitudes, beliefs, values, and behaviors, it is important to gain an awareness of the cultural determinants of our *own*, as well as our clients',* thoughts, feelings, and acts.

This manual is designed to help you, as a health care provider, increase your understanding of the cultural aspects of health and illness so that you can work effectively with individual clients and with families from culturally diverse communities. Information contained in each chapter will guide you in providing culturally sensitive and appropriate health education, counseling, and care in your various roles within the health care system. Just as all parts of a culture fit together and support one another, so, too, do the chapters of this manual reinforce succeeding ones. The information will be most useful if read in the order set forth.

■ ■ ■ Some Working Definitions

Before discussing specific cultural information, a review of some general cross-cultural principles and definitions is necessary. A *cultural group* is defined as people with common origins, customs, and styles of living. The group has a sense of identity and a shared language. Their shared history and experiences shape the groups' values, goals, expectations, beliefs, perceptions, and behaviors from birth until death. This definition includes both ethnic and religious minorities.

*Throughout this manual the term "client" is used to refer to any individual or group of individuals with whom the service provider is working. A client may be an adult, a child, or a family.

Racial minorities, however, do not necessarily qualify as cultural groups. A *racial minority* is one whose "members are readily identified by distinctive physical characteristics that are perceived as different from those of other members of society, such as skin color, hair type, body structure, shape of head, nose or eyes" (Axelson, 1985, p. 125). Although members of a racial minority might share a common cultural history, as in the case of Americans, they might have very different cultural experiences, as in the case of whites of Hispanic origin and whites of Anglo-Saxon heritage. Thus, we will confine our discussion to cultural groups comprised of ethnic and religious minorities in this manual.

Ethnocentrism is the tendency to view one's own cultural group as the center of everything, the standard against which all others are judged. It assumes that one's own cultural patterns are the correct and best ways of acting. Historically, many whites have judged culturally different clients in terms of values and behaviors of the white, dominant culture. This lack of understanding of, and respect for, ethnic and cultural differences has led to racism and discrimination which have been conveyed both subtly and overtly. In order to render culturally sensitive and appropriate care, it is necessary to identify how one's own cultural background impacts on ways of seeing and behaving. Exercises in Chapter 2 are designed to help health care providers identify ways their own cultural heritage influences their world view.

Cultural relativity is the idea that any behavior must be judged first in relation to the context of the culture in which it occurs. Thus, you must first relate to your client's interpretations of experiences from his or her own background and cultural belief system before you can effectively intervene.

However endless the diversity of cultural expressions appears, there are *cultural universals*. For example, the following structures or functions are found in every extended culture: a family unit, marriage, parental roles, education, health care, forms of work or endeavors to meet basic physiological needs, and forms of self expression that meet psychological and spiritual needs. This manual will focus on the universals that impact on issues relating to:

- family structure, roles, and relations;
- health beliefs, particularly related to chronic illness and disability;
- religious beliefs and their interrelationship with health beliefs;
- sexual attitudes and practices;
- drug usage patterns; and,
- styles of communication, particularly those that impact on education.

It must be emphasized that a holistic view is critical in understanding any cultural system. All parts of the culture must be seen within the larger context. To isolate one component or subsystem is to ignore the cultural complexity of the group. Thus, even though the focus of this manual is on health and illness, it is necessary to learn about the broader socio-economic, political, religious, and cultural context in which health is embedded. Guidelines designed to help readers learn about these aspects of the communities with which they will be working are included in Chapter 3.

As we learn about traits that are characteristic of a particular cultural group, we must remember to see each person as an individual. In part, the degree to which an individual client behaves, feels, and believes like others from his or her culture is dependent on the degree of acculturation.

Acculturation is a term which is used to describe the degree to which people from a particular cultural group display behavior which is like the more pervasive American norms of behavior. The degree to which people act like mainstream America is related to the amount and kind of exposure to dominant Anglo standards and behaviors. Factors that may lead to a higher degree of acculturation are: 1) a relatively high level of formal education, probably a minimum of several years of high school; 2) birth into a family that has lived in the United States for at least several years; 3) extensive contact with people outside their ethnic and/or family social network; 4) for immigrants, immigration to the U.S. at an early age; 5) urban, as opposed to rural, origin; 6) limited migration back and forth to the mother country; and, 7) higher socioeconomic status. Other factors influencing individual differences are age, sex, occupation, social class, religious affiliation, and family size.

Thus, when counseling a person from a cultural or ethnic group, it will be important to assess the degree to which the client has acculturated to mainstream America or retained his or her ethnic or traditional ways. These variables are important in deciding upon the most appropriate techniques and methods of intervention. Understanding clients from the perspective of their own situation, however different that is from the counselors' culture, is necessary in helping them deal with problems within their own culture and environment. Guidelines in Chapter 4 are helpful in assessing the individual client's values, beliefs, and practice.

Cultural values are the "standards people use to assess themselves and others . . . [A cultural value] is a widely held belief about what is worthwhile, desirable, or important for well being" (Schilling and Brannon, 1986, p. 2). Table 1 compares some common values held by many ethnocultural groups with those of Anglo-Americans.

A *culture broker* is a mediator between people or groups from two cultures. In the health care setting, this person understands both the health care belief systems of the client and family as well as the perspective of

TABLE 1
Comparison of Common Values

Anglo-American	Other Ethnocultural groups
Mastery over nature	Harmony with nature
Personal control over the environment	Fate
Doing--activity	Being
Time dominates	Personal interaction dominates
Human equality	Hierarchy/rank/status
Individualism/privacy	Group welfare
Youth	Elders
Self help	Birthright inheritance
Competition	Cooperation
Future orientation	Past or present orientation
Informality	Formality
Directness/openness/honesty	Indirectness/ritual/"face"
Practicality/efficiency	Idealism
Materialism	Spiritualism/detachment

(Adapted from Schilling and Brannon, 1986)

the biomedical health care culture. It is hoped that this manual will aid the reader in becoming a culture broker in mediating between clients from culturally diverse communities and the mainstream health care system. Chapters 3 and 4 provide concrete suggestions for learning about ethnic communities in order to provide culturally sensitive care to clients from diverse communities. Chapter 5 provides an overview of some relevant values, beliefs, and practices of various cultural groups (Asian Americans, Black Americans, Haitians, Hispanic/Latino Americans, and Amish Americans). These are accompanied by concrete suggestions for clinical and educational interventions.

Throughout this manual certain cultural principles are presented and discussed to guide the professional's work with different groups. *It is, however, critically important to remember that no cultural group is homogenous, and that every racial and ethnic group contains great diversity.* The principles that are set forth are not intended as hard and fast rules but rather as helpful guidelines for improving outreach to culturally diverse communities. In order to provide the most effective services to any community of people, professionals must be sensitive to the cultural values of the group while recognizing and respecting individual differences.

Assessing Your Own Cultural Heritage

The culture in which you are raised greatly influences your attitudes, beliefs, values, and behaviors. In order to provide sensitive and effective care to clients from cultures that are different from your own, two things must occur.

1. An awareness of your own cultural values and beliefs and a recognition of how they influence your attitudes and behaviors.
2. An understanding of the cultural values and beliefs of your clients and how they influence their attitudes and behaviors.

This chapter is designed to help you assess your own cultural heritage. Take a few minutes to do the following exercises. They will help you clarify your attitudes and beliefs and how these influence your ability to work with clients from diverse cultural backgrounds. There are no right or wrong answers to these questions. They are intended only to facilitate an acknowledgement of your own cultural heritage.

EXERCISE 1
Acknowledging Your Cultural Heritage

- What ethnic group, socioeconomic class, religion, age group, and community do you belong to?
- What experiences have you had with people from ethnic groups, socioeconomic classes, religions, age groups, or communities different from your own?
- What were those experiences like? How did you feel about them?
- When you were growing up what did your parents and significant others say about people who were different from your family?
- What about your ethnic group, socioeconomic class, religion, age, or community do you find embarrassing or wish you could change? Why?
- What sociocultural factors in your background might contribute to being rejected by members of other cultures?
- What personal qualities do you have that will help you establish interpersonal relationships with persons from other cultural groups? What personal qualities may be detrimental?

(Source: Hutchinson, 1986)

Answering the above questions honestly and completely is the important first step in self-awareness. The second step involves exploring beliefs and attitudes that may be different from, or the same as, those held by the client or client's family. Now ponder the following statements in Exercise 2, adapted from Henderson and Primeaux (1981, p. 55).

EXERCISE 2
Exploring Specific Cultural Attitudes

	Agree	Disagree
I would like to travel to different countries.	☐	☐
I accept opinions different from my own.	☐	☐
I respond with compassion to poverty-stricken people.	☐	☐
I think interracial marriage is a good thing.	☐	☐
I would feel uncomfortable in a group in which I am the ethnic minority.	☐	☐
I consider failure a bad thing.	☐	☐
I invite people from different ethnic groups to my home.	☐	☐
I believe that the Ku Klux Klan has its good points.	☐	☐
I am concerned about the treatment of minorities in employment and health care.	☐	☐
I tell (or laugh at) ethnic jokes.	☐	☐
The U.S. should tighten up its immigration policy.	☐	☐
People who speak a different language and who act different from me interest me.	☐	☐
The refugees should be forced to return home.	☐	☐
I feel uncomfortable in low-income neighborhoods.	☐	☐
I prefer to conform rather than disagree in public.	☐	☐
I spend a lot of time worrying about social injustices without doing much about them.	☐	☐
I believe that almost anyone who really wants to can get a good job.	☐	☐
I have a close friend of another race/ethnic group.	☐	☐
I would enjoy working with patients from a different racial/ethnic group.	☐	☐

A third exercise helps you to determine how you might relate to different types of individuals in our society. This exercise was adapted from the work of Louis Thayer by Axelson (1985).

EXERCISE 3
How Do You Relate to Various Groups of People in the Society?

Described below are different levels of response you might have toward a person.

Levels of Response:

1. *Greet:* I feel I can *greet* this person warmly and welcome him or her sincerely.
2. *Accept:* I feel I can honestly *accept* this person as he or she is and be comfortable enough to listen to his or her problems.
3. *Help:* I feel I would genuinely try to *help* this person with his or her problems as they might relate to or arise from the label-stereotype given to him or her.
4. *Background:* I feel I have the *background* of knowledge and/or experience to be able to help this person.
5. *Advocate:* I feel I could honestly be an *advocate* for this person.

The following is a list of individuals. Read down the list and place a check mark by anyone you would **not** "greet" or would hesitate to "greet." Then move to response level 2, "accept," and follow the same procedure. Try to respond honestly, not as you think might be socially or professionally desirable. Your answers are only for your personal use in clarifying your initial reactions to different people.

Level of Response

Individual	1 Greet	2 Accept	3 Help	4 Background	5 Advocate
1. Haitian	☐	☐	☐	☐	☐
2. Child Abuser	☐	☐	☐	☐	☐
3. Jew	☐	☐	☐	☐	☐
4. Person with Hemophilia	☐	☐	☐	☐	☐
5. Neo-Nazi	☐	☐	☐	☐	☐
6. Mexican American	☐	☐	☐	☐	☐
7. IV drug user	☐	☐	☐	☐	☐
8. Catholic	☐	☐	☐	☐	☐
9. Senile, elderly person	☐	☐	☐	☐	☐
10. Teamster Union member	☐	☐	☐	☐	☐
11. Native American	☐	☐	☐	☐	☐

(Continued on next page)

Exercise 3, Continued

Individual	1 Greet	2 Accept	3 Help	4 Background	5 Advocate
	Level of Response				
12. Prostitute	☐	☐	☐	☐	☐
13. Jehovah's Witness	☐	☐	☐	☐	☐
14. Cerebral palsied person	☐	☐	☐	☐	☐
15. E.R.A. proponent	☐	☐	☐	☐	☐
16. Vietnamese American	☐	☐	☐	☐	☐
17. Gay/Lesbian	☐	☐	☐	☐	☐
18. Atheist	☐	☐	☐	☐	☐
19. Person with AIDS	☐	☐	☐	☐	☐
20. Communist	☐	☐	☐	☐	☐
21. Black American	☐	☐	☐	☐	☐
22. Unmarried expectant teenager	☐	☐	☐	☐	☐
23. Protestant	☐	☐	☐	☐	☐
24. Amputee	☐	☐	☐	☐	☐
25. Ku Klux Klansman	☐	☐	☐	☐	☐
26. White Anglo-Saxon	☐	☐	☐	☐	☐
27. Alcoholic	☐	☐	☐	☐	☐
28. Amish person	☐	☐	☐	☐	☐
29. Person with cancer	☐	☐	☐	☐	☐
30. Nuclear armament proponent	☐	☐	☐	☐	☐

Scoring Guide: The previous activity may help you anticipate difficulty in working with some clients at various levels. The thirty types of individuals can be grouped into five categories: ethnic/racial, social issues/problems, religious, physically/mentally handicapped, and political. Transfer your check marks to the following form. If you have a concentration of checks within a specific category of individuals or at specific levels, this may indicate a conflict that could hinder you from rendering effective professional help.

Individual	1 Greet	2 Accept	3 Help	4 Background	5 Advocate
	Level of Response				
Ethnic/Racial					
1. Haitian American	☐	☐	☐	☐	☐
6. Mexican American	☐	☐	☐	☐	☐
11. Native American	☐	☐	☐	☐	☐
16. Vietnamese American	☐	☐	☐	☐	☐
21. Black American	☐	☐	☐	☐	☐
26. White Anglo Saxon	☐	☐	☐	☐	☐

(Continued on next page)

Exercise 3, Continued

Individual	Level of Response 1 Greet	2 Accept	3 Help	4 Background	5 Advocate
Social Issues/Problems					
2. Child abuser	☐	☐	☐	☐	☐
7. IV drug user	☐	☐	☐	☐	☐
12. Prostitute	☐	☐	☐	☐	☐
17. Gay/Lesbian	☐	☐	☐	☐	☐
22. Unmarried expectant teenager	☐	☐	☐	☐	☐
27. Alcoholic	☐	☐	☐	☐	☐
Religious					
3. Jew	☐	☐	☐	☐	☐
8. Catholic	☐	☐	☐	☐	☐
13. Jehovah's Witness	☐	☐	☐	☐	☐
18. Atheist	☐	☐	☐	☐	☐
23. Protestant	☐	☐	☐	☐	☐
28. Amish person	☐	☐	☐	☐	☐
Physically/Mentally Handicapped					
4. Person with Hemophilia	☐	☐	☐	☐	☐
9. Senile elderly person	☐	☐	☐	☐	☐
14. Cerebral palsied person	☐	☐	☐	☐	☐
19. Person with AIDS	☐	☐	☐	☐	☐
24. Amputee	☐	☐	☐	☐	☐
29. Person with cancer	☐	☐	☐	☐	☐
Political					
5. Neo-Nazi	☐	☐	☐	☐	☐
10. Teamster Union member	☐	☐	☐	☐	☐
15. E.R.A. proponent	☐	☐	☐	☐	☐
20. Communist	☐	☐	☐	☐	☐
25. Ku Klux Klansman	☐	☐	☐	☐	☐
30. Nuclear armament proponent	☐	☐	☐	☐	☐

The next exercise (Axelson, 1985, p. 15) is intended to help you understand your social identity.

EXERCISE 4
Getting in Touch with Your Own Social Identity

Identifying Your Social Roles

1. Circle the items in each of the four columns that best describe you.
2. Place a check mark by the items you circled that seem to be **most** important or significant for any reason to you at this time in your life.

A	B	C	D
Lower economic class	Anglo-Saxon American	Female, male	Business person
Middle economic class	Anglo	Married, single, separated, divorced	White-collar worker
Upper economic class	White		Professional
	Ethnic		Technician
Militant	Black	Wife, husband	Blue-collar worker
Radical	African-American	Mother, father, step-parent, godparent	Skilled worker
Liberal	Negro		Student
Moderate		Grandmother, grandfather	Service provider
Conservative	Hispanic		
Reactionary	Latino	Aunt, uncle, niece, nephew, cousin	Laborer
Indifferent	Chicano		
	Latin-American, Hispano, Latin, Hispano Hablante, Spanish-speaking	Daughter, son, step-child, grandchild	Other: _____
Republican		Sister, brother, half-sister, half-brother, step-brother, step-sister	
Democrat			
Independent			
	Asian American		
	Asian		
	Oriental		
	Native American		
	Indian		
	American Indian		
	Amerindian, Amerind		
	Other: _____		

(Continued on next page)

Exercise 4, Continued

How Did You Identify Yourself?

1. I best describe myself as a (an):

Column A: _____

Column B: _____

Column C: _____

Column D: _____

2. According to my check marks, the most important roles in my life at this time are: _____

Some Discussion Questions

With the above descriptions in mind, consider the following questions:

1. What are the advantages and disadvantages of being this kind of person in my personal life today? My working life?
2. What are the advantages and disadvantages of being this kind of person in the majority community?
3. What are the advantages and disadvantages of being this kind of person in minority communities?

A final exercise, adapted from Axelson (1985), involves reading through a list of assumptions and behaviors of both blacks and whites that can either block or facilitate authentic relations. Although this list was generated almost 20 years ago, many, if not all, points in the list continue to be applicable today. Furthermore, although this focuses on black-white relations, most of the dynamics could apply to any cross-cultural relationship, especially Anglo-American relations with other ethnic minorities. Do any of these "ring true" for you?

EXERCISE 5
White/Black Interpersonal Relations

Assumptions That Whites Make Which Block Authentic Relations

1. Color is unimportant in interpersonal relations.
2. Blacks will always welcome and appreciate inclusion in White society.
3. Open recognition of color may embarrass blacks.
4. Blacks are trying to use whites.
5. Blacks can be stereotyped.
6. White society is superior to black society.
7. "Liberal" whites are free of racism.
8. All blacks are alike in their attitudes and behavior.
9. Blacks are oversensitive.
10. Blacks must be controlled.

Assumptions That Blacks Make Which Block Authentic Relations

1. All whites are alike.
2. There are no "soul brothers and sisters" among whites.
3. Honkies have all the power.
4. Whites are always trying to use blacks.
5. Whites are united in their attitude toward blacks.
6. All whites are racists.
7. Whites are not really trying to understand the situation of the blacks.
8. Whites have got to deal on black terms.
9. Silence is the sign of hostility.
10. Whites cannot and will not change except by force.
11. The only way to gain attention is through confrontation.
12. All whites are deceptive.
13. All whites will let you down in the "crunch."

Assumptions That Whites Can Make Which Will Facilitate Authentic Relations

1. People count as individuals.
2. Blacks are human -- with individual feelings, aspirations, and attitudes.
3. Blacks have a heritage of which they are proud.
4. Interdependence is needed between whites and blacks.
5. Blacks are angry.
6. Whites cannot fully understand what it means to be black.
7. Whiteness/blackness is a real difference but not the basis on which to determine behavior.
8. Most blacks can handle whites' authentic behavior and feelings.
9. Blacks want a responsible society.
10. Blacks are capable of managerial maturity.
11. I may be part of the problem.

(Continued on next page)

Exercise 5, Continued

Assumptions That Blacks Can Make Which Will Facilitate Authentic Relations

1. Openness is healthy.
2. Interdependence is needed between blacks and whites.
3. People count as individuals.
4. Negotiation and collaboration are possible strategies.
5. Whites are human beings and, whether they should or not, do have their own hang-ups.
6. Some whites can help and "do their own thing."
7. Some whites have "soul."

Behaviors of Whites Which Block Authentic Relations

1. Interruptions.
2. Condescending behavior.
3. Offering help where not needed or wanted.
4. Avoidance of contact (eye-to-eye and physical).
5. Verbal focus on black behavior rather than white behavior.
6. Insisting on playing games according to white rules.
7. Showing annoyance at black behavior which differs from their own.
8. Expressions of too-easy acceptance and friendship.
9. Talking about, rather than to, blacks who are present.

Behaviors of Blacks Which Block Authentic Relations

1. Confrontation too early and too harshly.
2. Rejection of honest expressions of acceptance and friendship.
3. Pushing whites into such a defensive posture that learning and re-examination are impossible.
4. Failure to keep a commitment and then offering no explanation.
5. "In-group" joking, laughing at whites -- in black culture/language.
6. Giving answers blacks think whites want to hear.
7. Using confrontation as the primary relationship style.
8. Isolationism.

Behaviors of Whites Which Facilitate Authentic Relations

1. Directness and openness in expressing feelings.
2. Assisting other white brothers and sisters to understand and confront feelings.
3. Supporting self-initiated moves of black people.
4. Listening without interrupting.
5. Demonstration of interest in learning about black perceptions, culture, etc.
6. Staying with, and working through, difficult confrontations.
7. Taking a risk (being first to confront the differences).
8. Assuming responsibility for examining own motives.

(Continued on next page)

Exercise 5, Continued

Behaviors of Blacks Which Facilitate Authentic Relations

1. Showing interest in understanding whites' point of view.
2. Acknowledging that there are some committed whites.
3. Acting as if "we have some power" -- and don't need to prove it.
4. Allowing whites to experience racism.
5. Openness.
6. Expression of real feelings.
7. Dealing with whites where they are.
8. Meeting whites half-way.
9. Treating whites on one-to-one basis.
10. Telling it like it is.
11. Realistic goal-sharing.
12. Showing pride in their heritage.

Hopefully, these exercises have increased your awareness of the ways in which your own cultural heritage influences your attitudes and behavior. Just as the cultural background of the client or of the client's family shapes their beliefs and practices, so, too, does the service provider's cultural heritage affect his or her world view. Just as we each feel a commitment to our own values and attitudes, so, too, do the individuals and families with whom we work feel strongly about theirs. In order for us to implement culturally appropriate outreach and provide culturally sensitive health care, we must remain ever mindful of these cultural principles. A good rule to follow is that of treating clients in ways in which we would want to be treated.

Even among people from very different cultural backgrounds, there are commonalities of experience. Discovering the experiences and beliefs that you share with clients will help you relate to them as individuals rather than as a stereotype. Do you have a similar hobby or leisure activity? A similar role, such as parent or teacher? Draw upon these similarities to establish rapport and build trust. It helps the client see you as a person rather than as someone just doing a job. Often the time spent discovering and building upon these common experiences is time well spent.

If, after honest attempts at working with certain clients or communities, you still feel discouraged about your effectiveness, ask for help. Not all people work equally well with all people. Recognize your limits and recruit the help of others when necessary.

Learning About the Community

Now that you understand more about how your own cultural heritage influences your world view, you are ready to learn about the cultural values, beliefs, and practices of the community you are trying to reach.

How does one get started on what seems like an overwhelming task? The following suggestions are excerpted from a variety of sources, including texts designed for health care providers working in developing countries as well as from manuals targeted for those working in our own country. There are three components of the process:

- conducting a community assessment;
- developing relationships with key persons in the community; and,
- marketing your services to community groups and to your targeted population.

■ ■ ■ Conducting a Community Assessment

The best first step is to look and listen before asking or acting.

Participate as an observer in meetings, clinics, religious events, and other community gatherings. Notice similarities to as well as differences from the dominant culture in the way the community participates in these events.

Make the following lists in order to conduct a community assessment.

- A list of all the institutions the target population utilizes; such as schools, churches, hospitals, and clinics.
- A list of all social service agencies that serve the community; such as public welfare (AFDC), food stamps/WIC, tribal councils, United Way, community action agency, public housing, community health clinics, mental health clinics, drug treatment facilities, Black United Fund.
- A list of the key community businesses patronized by the target population; such as grocery and clothing stores, beauty parlors/barber shops, restaurants, pharmacies, taverns and bars.
- A list of the community leaders; such as clergy/pastoral care, local minority legislators, city and county commissioners, youth leaders (including gang leaders), business owners, sports figures and coaches, teachers, school counselors and principals, agency directors, leaders of community groups, musicians, and media specialists and personalities.

Review the ways to gather information.

- In-depth interviews -- asking one or several people many questions that allow for long and free responses.
- Informal conversation -- allowing the conversation to follow its own course and listening carefully for key information. Listen to stories and jokes and learn from them.
- Survey research -- asking a number of people the same series of questions either through administration of individual questionnaires or through focus group interactions.
- Observations -- observing the everyday life or specific events in the life of the community.
- Content analysis or secondary research -- studying or analyzing documents, newspapers, books, and movies to gain an understanding of the culture.
- Experimental research -- in which you set up a situation, carry out planned changes, and observe the results.
- Case studies -- intensive study of certain aspects of one person, family, or situation.

Determine the special areas you need to learn more about.

Guidelines for an in-depth analysis of sociocultural factors in health are included in Appendix B. Review these to guide you in devising a series of questions for your own interview schedule. Some topics you might include are: community views of health, chronic illness, disability, views toward biomedical medicine, mental health counseling, sexuality, family support, importance of children, and attitudes toward death and dying.

Identify a close confidant

Identify someone who may help you "bridge the gap" between cultures. Make sure the confidant you select is still in touch with his or her culture. Often the people most accessible to a newcomer are those who relate more to outsiders than to those within their community. Therefore, they may not be representative of the community. Be aware that in all communities, cliques or subgroups exist. Gather information and generate referrals to other community members from people representing various subgroups, age groups, and both sexes.

Follow these guidelines when formulating your questions.

- Check out your questions with a few key community members before starting.
- Try asking yourself the same questions about your own culture.

- Learn how to interview within the local area -- the do's and don't's of interviewing may vary greatly from place to place.
- Learn *when* to ask questions and when not to ask them.
- Learn *what* questions to ask and what ones not to ask. What topics are considered taboo, too personal?

Interview other professionals or agency staff who have worked with the target population.

Interview community leaders.

Find out who the informal opinion leaders are.

These people often are not those identified as community leaders but in many cases have more influence than the identified leaders.

Talk with those who are considered "wise" within the community.

For example, seek out an elder in the Native American Community, a granny midwife or herbalist in a rural Black community.

Talk with as many people as possible.

Gain a truly comprehensive understanding -- no two or three people can possibly tell you about all aspects of community life.

Remember that all information contains both subjective and objective aspects.

Verify and cross check the information you collect.

Review the following list of typical problems in gaining accurate information.

- Mistrust or reserve may be the typical response within the culture until the questioner moves out of the category of "stranger."
- Mistrust may prevail because you haven't yet proved yourself trustworthy; the "proof" that makes trust possible may vary from situation to situation.
- Interviewees may wish to tell you what they think you want to hear.
- You may be asking the wrong people.
- Your interviewees may mistake the ideal for the real.
- You may be asking the wrong questions.
- You may be asking questions at the wrong time or place.
- People may have difficulty describing and explaining those things that are second nature to them.

- What an interviewee says may be altered during translation.
- Your own characteristics may influence the response.

Avoid the pitfalls of stereotyping and making generalizations due to:

- Forming impressions too soon;
- Drawing incompletely formed conclusions before you understand the viewpoint of the community you are learning about;
- Generalizing from a non-typical group to the entire community; or,
- Forgetting that individual variations exist within the community.

Above all, be sincere, open, and honest.

When appropriate, share your own experiences, beliefs, and practices with those you talk with as a means of building rapport. Most people prefer mutual exchanges to one-sided interviews.

Guidelines for Working with Culturally Diverse Community Groups and Clients

Once upon a time a monkey and a fish were caught up in a great flood. The monkey, agile and experienced, had the good fortune to scramble up a tree to safety. As he looked down into the raging waters, he saw a fish struggling against the swift current. Filled with a humanitarian desire to help his less fortunate fellow, he reached down and scooped the fish from the water. To the monkey's surprise, the fish was not very grateful for this aid. (Old Chinese fable, quoted in Foster, 1962).

You are armed with an awareness of your own cultural heritage. You understand a lot more about the sociocultural aspects of the community you're trying to reach. You genuinely want to be helpful. Everything is going great. Right? Not great, actually. You sense some resistance on the part of the community in general and from certain clients in particular. Where does this resistance come from?

- Many minority communities have a long history of outsiders coming into their community to "rescue" their members from some inherent danger. Although well meaning, many of these programs were ineffective because they did not involve community members in their planning and implementation. Some actually perpetuated discrimination and racism.

- Many minority communities resent outsiders receiving funds for working with their members while the community itself suffers from economic stressors. They do not want to be told by outsiders what their problems are and how to solve them. In the spirit of community pride and self-determination, they want funding and technical assistance to enable them to help their own people.

- Many minority communities believe that they are in the best position to provide culturally appropriate interventions since they best know the community communication networks and the culturally determined *beliefs, values, attitudes, and behaviors* of community members (Jenkins, 1988).

How then can you deal with these obstacles?

One of the best ways to get the community to work with you is to hire staff members from within the community. Not only will minority staff

members facilitate communications with various segments of the community but they will also provide invaluable insight into community dynamics, cultural beliefs and practices, and residential location of specific families. These contributions will be most helpful in identifying clients, and in education, counseling, and treatment. However, don't assume that a person is sensitized to the cultural issues solely by virtue of being a member of that group. There are many variables that need to be considered, such as economic status, social class, age, and experience. The same rigorous interviewing process should be engaged in for all applicants. If there are no paid staff positions, community members can be recruited for volunteer work. This alternative is clearly less desirable but may function as an interim measure during periods of limited resources.

Once you have hired staff, identify the characteristics of the population you are trying to reach. For example, your list might include: persons with hemophilia, black, male, age 17-45 years, HIV positive.* The list might be expanded to include female sexual partners or a greater age range. It might target a different ethnic or religious minority. Each program will have a different target group.

Next make a list of all the agencies that serve people with *any* of these characteristics. Using the characteristics noted above, the list would include all agencies that serve persons with hemophilia, blacks, men, people aged 17-45 years, and HIV positive individuals. Thus, the types of local agencies might include Hemophilia treatment centers; private and municipal hospitals including emergency rooms; inpatient units and outpatient clinics; blood banks; vocational rehabilitation offices; pharmaceutical companies; local Red Cross offices; sexually transmitted disease clinics; Planned Parenthood or other family planning clinics; Sickle Cell clinics; drug treatment facilities; prenatal clinics; well-baby clinics; migrant health clinics; mental health facilities; Crippled Children's Program offices; Community Action Agencies; vocational and technical school programs as well as high schools, junior colleges, colleges and professional schools; food stamps, AFDC, and WIC programs; black fraternities and sororities; other black social clubs; Black United Fund; Black Nurses Association; community-based AIDS organizations; AIDS task forces or coalitions; HIV testing and counseling sites; and hospitals treating AIDS patients. Since women in most cultures are responsible for the health care of the entire family, it will be important to target your outreach efforts to women as well as men.

Next generate a list of places where community members gather. This might include restaurants (including fast food chains), pool halls, school

*Throughout the chapter, this example of outreach to black males with hemophilia regarding AIDS education and prevention will be used. The principles presented in this chapter however, can be applied to community outreach to any group of clients.

yards, parks, bowling alleys, bars or juke joints, day care centers, housing projects, corner hangouts, malls, recreation centers (including the YWCA and YMCA), Boys & Girls Clubs, playgrounds, and drugstores.

Review your list of businesses that are patronized by the target population and the list of formal and informal community leaders (see p. 15) and then generate a list of media that reach the target population -- particularly minority-run radio and TV stations, community newspapers, and magazines. Together, all these lists will yield a comprehensive catalogue of local resources. Some of these resources will be most helpful in identifying clients, others in education, and still others in counseling and treatment. Some resources will be useful in more than one aspect of the community outreach effort. Using your master list, go through each entry and mark "C" for identifying clients, "E" for education, "M" for mental health counseling, and "T" for treatment in the left-hand margin.

■ ■ ■ Identifying Clients

Identification of community-based groups. Review the resources on your master list that might be helpful in finding prospective clients. Research these organizations to determine their function and effectiveness. Are their goals compatible with the casefinding efforts in your project? Are they effective in accomplishing their goals?

Development of working relationships. With which of the agencies or organizations on your list do you already have a working relationship? These might be the best places to begin your efforts. However, identifying clients solely through institutions, such as hospitals and clinics, will not be nearly as effective as working with community-based organizations. Expand your horizons once you have your bearings. Reach out to the community-based groups that are already familiar with the target population. Again, you will need to assess how much education is needed for them to aid in the casefinding efforts. What means will best accomplish this -- training sessions? printed materials? audiovisuals? other methods?

Identify a contact person in each organization with whom you can collaborate. Cultivate this relationship through regular phone calls and meetings. Be sure to emphasize how you can help their organization achieve their goals. Reciprocity and mutual aid will insure a more successful partnership.

Provision of materials. What materials, if any, will aid the agency or organization in finding clients? Posters, pamphlets or other handouts, films, or videos? How can information about your program be integrated into the activities and goals of the organization?

Development of mechanisms for client referral. What mechanism will be used for others to refer clients to your program once they have been identified or located? A written protocol for this procedure may be necessary to avoid problems later. Consider scheduling regular meetings or telephone calls for follow-up. How many persons with hemophilia have been identified? Did they get to the hemophilia treatment center? Were any difficulties or problems encountered? What were the successful components of the transaction? Give staff at the hemophilia treatment center any feedback gained through this communication.

Valuing the contributions of all organizations. Keep in mind that the level of involvement in finding clients will vary from organization to organization. Some will hand out printed materials in their waiting rooms, others will incorporate information about hemophilia and AIDS in their community presentations, while others will interview clients at possible risk. Any and all efforts will be helpful and should be encouraged.

■■■ Education

Identification of resources. Review your master list on page 20. Identify existing resources on the local, state, and national level that could assist your education efforts. Generate a new list of state resources, such as the AIDS Program Office, Maternal and Child Health, Children's Medical Services, Sickle Cell Program Office, Migrant Health, State Commission on Civil Rights/Human Rights, State AIDS Task Force, State Drug Treatment Programs, and State Mental Health Programs. Consult the list of national resources included in Appendix C.

Review of existing education materials. Review the materials that are available through local, state, and national organizations to identify resources you can utilize in your educational efforts. For educational materials in hemophilia utilize sources available through the National Hemophilia Foundation, the Canadian Hemophilia Society, and the World Hemophilia Federation.

Development of educational materials. Develop culturally appropriate educational materials for the target population if none exist. The following suggestions will provide guidance.

- Get community input when designing new materials. Find out what types of educational efforts have worked well in the past, and, conversely, what strategies should be avoided.

- Remember the cultural values, beliefs and practices identified in Chapter 3 and incorporate these into your educational materials.

- Use the language spoken by the target population, but avoid direct translations of previously existing materials. Direct translations are generally inappropriate.

- Use words and phrases that are used by the target population, not medical terms or euphemisms. For example, "avoid the exchange of bodily fluids," a phrase found in many AIDS brochures, is meaningless to most people. Be as explicit and direct as the culture will tolerate.

- Give a direct and nonjudgmental message that is locally and regionally relevant.

- Ascertain the reading level of the target population and design printed materials aimed at that level.

- Use pictures, cartoons, comics, posters, and other visual representations for target populations with limited reading ability.

- Keep written materials brief.

- Consider the use of other types of educational materials such as audiocassettes, videotapes, films, slide shows, songs, games, and plays.

- Use cultural heroes as spokespersons or endorsers for your educational effort. Religious leaders, sports figures, movie stars, musicians, and political leaders can often add the validation your program needs.

- Have contests for community members to design educational materials.

- Remember that education is a process, oriented toward active participation of learners in order to impart new knowledge, skills, and attitudes. Whatever educational materials you choose, be sure they are designed to involve the learner.

Dissemination of educational materials. Work with community-based organizations, institutions, and agencies to distribute the culturally relevant educational materials. Take every opportunity to get your message out. Good exposure can be gained through: health fairs, carnivals, neighborhood festivals, and sporting or musical events. Print media such as feature stories in local newspapers, flyers, and signs and posters are also effective. Other, more expensive, approaches to dissemination include billboards and public service announcements.

Work with community-based groups to provide educational workshops. A team approach that uses a staff member from your program and one from a community-based group is usually most effective. This is especially true if you do not have a minority person on staff. Be aware, however, that not all groups respond well to lectures and workshops; develop a range of formats for your presentations.

■■■ Counseling

Members of most cultural groups tend to use mental health agencies as a last resort, only after they have exhausted resources in their natural support systems and the problems have become so chronic and severe that the outlook for treatment and alleviation of symptoms is poor. Therefore, they are more likely to be at higher risk when they are seen. This under-utilization of mainstream mental health agencies and social services stems from: 1) language problems; 2) low awareness of community mental health programs; 3) limited access to mental health services; 4) stigma attached to needing such services; 5) negative past experience with agencies that have created distrust, suspicion, fear of agencies, and unfavorable attitudes toward mental health care; and, 6) mental health services' lack of interest in, and sensitivity to, the needs of culturally diverse clients so that clients have been "treated" without proper awareness or concern for cultural differences.

Therefore, traditional mental health agencies may not be very helpful in your outreach effort. Consult with the local mental health resources to determine whether or not these agencies are utilized by the target population. If they are, network with staff from these agencies. If not, learn more about how community members deal with emotional problems. Views toward mental health services and preferred modes of intervention, treatment, and therapeutic agent are culturally determined. Review the following list of cross-cultural differences so you can take these into account when counseling clients from cultures other than your own.

1. **Differences in attitudes toward receiving psychiatric or mental health care.**

   In some cultures, loss of status, fear of being seen as a failure, and shame accompany psychiatric help-seeking behaviors.

2. **Differences in verbal expressiveness in talking about one's family problems with a stranger.**

   Some cultures are very expressive while others are much more closed.

3. **Differences in culture specific intervention strategies.**

   Some cultures employ particular rituals and techniques to resolve an individual's problems.

4. **Differences in definitions of abnormal behavior.**

   What is perceived as psychopathology in one culture might be sanctioned, even encouraged, in others.

5. **Differences in explanations of the causes of abnormal behavior.**

   The underlying cause of abnormal behavior may be seen to be physiological or psychological in nature. Or the behavior may be viewed to be the result of actions of others (living or dead) or supernatural or spiritual forces.

6. **Differences in style of intervention preferred.**

   In general, cultures relying on internal controls promote insight-oriented therapy while cultures relying on external controls are more amenable to directed therapies. For those oriented towards the "guidance-nurturant" approach, clients expect the counselor to take an active and directive role and give them explicit directions on how to solve problems and bring immediate relief from their distress. To these people, the nondirective approach is seen as uncaring and indifferent. In order to reduce uncertainty, the counselor first must clarify what is planned in therapy and why. Counseling methods which rely on introspection, reflection, and extensive client verbalization do not meet the needs of these cultural groups.

7. **Differences in views of long-term vs. immediate goals.**

   Some cultures are more present-oriented while others are more future-oriented. Those with a present orientation will be frustrated by therapies focused on long-term, future-oriented change.

8. **Differences in individual vs. group approach to problem solving.**

   Black Americans and Hispanic Americans tend to stress cooperation among family and the community group to help individuals in distress, whereas mainstream Anglo-Americans generally place greater value on individual solutions to problems.

9. Differences in therapeutic agents or people whose help is sought for psychosocial disorders.

Mainstream White American	*Black American*	*Haitian*	*Native American*
Counselors Psychiatrists Psychologists Social Workers Ministers	Ministers Root workers Voodoo priests Spiritualists	Voodoo priests	Medicine men "Singers"

Mexican American	*Puerto Rican*	*Cuban*	*Southeast Asian American*
Curanderos	Espiritistas Santerios	Santerios	Herbalists Family/friends Diviner

Because of these differences in attitudes toward counseling it may be most effective to work with community-based health care agents. The following example from Hutchinson (1986) demonstrates the importance of understanding the cultural belief system of the client and of working collaboratively with the established psychosocial healer in the community.

> Henri, a twenty-one-year-old Haitian refugee, was brought by his family to the emergency room of a large general hospital in Miami. Family members believed Henri to be possessed by an evil spirit. They told the emergency room staff that they had been unable to control him for two days. He had been breaking dishes and glasses in the family's small apartment, shouting obscene curses in Creole at his mother, and attacking his brother on a number of occasions, screaming, "I am God the Son." Psychiatrists summoned by the ER staff noted that he was out of contact with reality, prescribed massive doses of tranquilizers, and arranged for his transfer to the inpatient psychiatric unit, where Henri remained for three more days with no decrease in his violent behavior. A surgical staff nurse who had been raised in Cuba and was familiar with Santeria (Cuba's folk blend of Catholicism and mysticism) heard of Henri's strange behavior. She suggested to one of her colleagues on the psychiatric unit that a voodoo practitioner might be helpful. After the psychiatric nurse confirmed that the family did believe in voodoo, she brought the suggestion to a team conference. After much heated discussion, the team decided to try an exorcism by a voodoo priest if the family agreed. The exorcism was carried out at the offices of a community mental health outreach center in Miami's Little Haiti. An inpatient psychiatric staff who observed the exorcism ceremony found that the client became very quiet after it. Henri returned to the unit where traditional treatment was continued and he improved rapidly.

■ ■ ■ Treatment

One of the major goals of the example we are using -- the hemophilia community outreach project -- is identification of persons with hemophilia from minority communities in order to involve them in the comprehensive hemophilia treatment system. In order to insure that the hemophilia treatment center provides culturally sensitive and appropriate care once the client enters the system, it may be necessary for your program to provide educational workshops for the treatment center staff. Sharing with them the cultural information you have gathered through your community assessment will facilitate their understanding of the client's background. Hopefully, if misunderstandings and negative attitudes toward clients exist, an increased understanding of cultural differences will lead to more accepting and nonjudgmental attitudes on the part of hemophilia treatment center staff.

During staff training it is important to emphasize that although there are many similarities among clients from a particular ethnic group, each client must be seen as an individual who may or may not adhere to the particular beliefs and practices described. This admonition will warn against stereotyping and overgeneralization.

There are several mechanisms for learning about an individual client's or family's beliefs, attitudes, and practices. Bloch's Ethnic/Cultural Assessment Guide is a comprehensive tool for gathering indepth information about the client's life history, cultural beliefs, and attitudes toward illness and health. It is presented in Appendix B.

A faster way of learning about an individual client's specific health beliefs and practices utilizes an opening statement proposed by Harwood (1981).

> I know that patients and doctors (nurses/social workers/ health educators) sometimes have different ideas about diseases and what causes them. So it's often important in treating a disease to get clear on how both the doctor and the patient think about it. That's why I'd like to know more about your ideas on (hemophilia or whatever disease or symptom is relevant to the situation). That way I can know what your concerns are, and we can work together in treating your sickness.

This opening is followed by a series of questions designed to gain an understanding of the client's perceptions of his or her illness (Randall-David, 1985, p. 1982).

1. What do you think caused your problem? Why do you think it started when it did?
2. What do you think your sickness does to your body? How does it work?
3. How severe is your sickness? How long do you think it will last?
4. What are the main problems your sickness has caused for you?
5. Do you know anyone else who had this problem? What did they do to treat it?
6. Did you discuss your problem with any of your relatives or friends? What did they say?
7. What kinds of home remedies, medicines, or other treatments have you tried for your sickness? Quantity/Dosage? Frequency? How prepared? Did it help? Are you still using it/them?
8. What type of treatment do you think you should receive from me? What are the most important results you hope to receive from this treatment?
9. Do you think there is any way to prevent this problem in the future? How?
10. Is there any other information that would be helpful for designing a workable treatment plan?

It is far more efficacious to spend time eliciting answers to these questions so that culturally relevant interventions can be planned, than to waste time planning care that will be irrelevant to the patient and thus ignored.

You may want to add other questions that will elicit information specifically related to the health concern on which your efforts are focused. These questions are most effective if asked in an open-ended fashion, allowing the client time to elaborate on his or her response. The more information you are able to elicit, the more culturally appropriate your interventions will be.

The Five "A's"

Comprehensive treatment must be *available, affordable, accessible, appropriate,* and *acceptable* to be utilized by clients. Strategies to make care appropriate and acceptable have been discussed. Comprehensive treatment programs must also be designed in ways that enhance client access to care.

Two important considerations are the flexibility of treatment center hours and the provision of transportation to the center for clients. Treatment programs should schedule regular evening clinics in addition to daytime hours. Strategies for helping clients get to the clinic include providing stipends for travel, a clinic-run bus or van service, networking with other community agencies to provide transportation, and the development of travelling clinics or mobile sites. Clinic appointments with different providers should be coordinated to reduce the number of visits a client is required to make.

Finally, in order to ensure that comprehensive treatment is truly available to all clients, it must be affordable. And yet, comprehensive care for chronic diseases can be very costly. Suggestions for overcoming the financial barriers to care include: seeking state funds; forming coalitions with other groups and organizations to create legislation for insurance coverage; hiring staff or training existing staff to assist patients in obtaining insurance; developing an information clearinghouse of reimbursement possibilities; and directly subsidizing insurance premiums or care.

It is important to address the financial problems with treatment center personnel. In the past, health care institutions have resisted outreach efforts which encourage minority participation because they were afraid of the economic repercussions of greater numbers of nonpaying clients. Certainly not all ethnic minority clients are indigent, but it is true that a large number may have difficulty affording comprehensive care. Staff providing services to these clients will need to collaborate closely with other community resource organizations to overcome this very difficult barrier to affordable and accessible health care.

Guidelines for Using Interpreters to Enhance Cross-Cultural Communication

If you are working with clients who speak a different language from your own, there can be problems in cross-cultural communication. To facilitate communication, consider the use of an interpreter or translator.

■ ■ ■ How to Choose an Interpreter

1. Ideally, an interpreter should be someone who is
   - trained in cross-cultural interpretation;
   - trained in the health care field;
   - proficient in the language of the client and that of the professional; and,
   - able to understand and respect the culture of the client and that of the health care professional.

   These interpreters are ideal because they not only translate the interaction but also bridge the culture gap.

2. In the absence of a trained interpreter, use a volunteer with training in medical terminology, an understanding of the significance of the particular health matter they will be translating, and an understanding of the importance of confidentiality.

3. Avoid relying on hospital personnel who are bilingual if they have not had some training as an interpreter.

4. Be cautious about the use of family members -- especially those of a different age or sex from the client. Clients are often embarrassed to discuss intimate matters with members of the opposite sex or with younger or older members of their family. Family members may wish to censor what is said to either shield the client or to keep information within the family.

5. Be sensitive to the client's right to privacy and their choice of who should act as an interpreter. Often there are problems when the interpreter is of a different social class, educational level, age, or sex.

   There can also be concerns about confidentiality if the interpreter is from the same community as the client.

■■■ How to Work With an Interpreter

1. Meet regularly with the interpreter in order to keep communications open and facilitate an understanding of the goals and purpose of the interview or counseling session. Certainly you should meet with the interpreter before meeting with the client.

2. Encourage the interpreter to meet with the client before the interview to find out about the client's educational level and his or her attitudes toward health and health care. This information can aid the interpreter in the depth and type of information and explanation that will be needed.

3. Speak in short units of speech -- not long involved sentences or paragraphs. Avoid long, complex discussions of several topics in a single interview.

4. Avoid technical terminology, abbreviations, and professional jargon.

5. Avoid colloquialisms, abstractions, idiomatic expressions, slang, similes, and metaphors.

6. Encourage the interpreter to translate the client's own words as much as possible rather than paraphrasing or "polishing" it into professional jargon. This gives a better sense of the client's concept of what is going on, his or her emotional state, and other important information.

7. Encourage the interpreter to refrain from inserting his or her own ideas or interpretations, or omitting information.

8. To check on the client's understanding and the accuracy of the translation, ask the client to repeat instructions or whatever has been communicated in his or her own words, with the translator facilitating.

9. During the interaction, look at and speak directly to the client, not the interpreter.

10. Listen to the client and watch their nonverbal communication. Often you can learn a lot regarding the affective aspects of the client's response by observing facial expressions, voice intonations, and body movements.

11. Be patient. An interpreted interview takes longer. Careful interpretation often requires that the interpreter use long explanatory phrases.

Even if you are using an interpreter, there are ways you can become more actively involved in the communication process.

1. Learn proper forms of address in the client's language. Use of these titles conveys respect for the client and demonstrates your willingness to learn about their culture.

2. Learn basic words and sentences of the client's language. Become familiar with special terminology used by clients. Even though you can't speak well enough to communicate directly, the more you understand, the greater the chance you will pick up on misinterpretations and misunderstandings in the interpreter-client interchange.

3. Use a positive tone of voice that conveys your interest in the client. Never be condescending, judgmental, or patronizing.

4. Repeat important information more than once. Always give the reason or purpose for a treatment or prescription.

5. Reinforce verbal interaction with materials written in the client's language and with visual aids.

■ ■ ■ Nonverbal Communication

Much of what is communicated is not verbalized but conveyed through facial expressions and body movements that are specific to each culture. It is important to understand the cross-cultural variations in order to avoid misunderstandings and unintentional offenses.

- **Silence.** Some cultures are quite comfortable with long periods of silence while others consider it appropriate to speak before the other person has finished talking. Learn about the appropriate use of pauses or interruptions in your client's culture.

- **Distance.** Some cultures are comfortable with close body space, while others are more comfortable at greater distance. In general, Anglo Americans prefer to be about an arm's length away from another person while Hispanics prefer closer proximity and Asians prefer greater distance. Give your client the choice by inviting him or her to "have a seat wherever you like."

- **Eye contact.** Some cultures advise their members to look people straight in the eye (Anglos) while others consider it disrespectful (blacks), a sign of hostility or impoliteness (Asians, Native Americans). Observe the client when talking and listening to get cues regarding appropriate eye contact.

- **Emotional expressiveness** varies greatly from one culture to another. Some cultures value stoicism while others encourage open expressions of such emotions as pain, joy, and sorrow. Asian Americans may smile or laugh to mask other emotions.

- **Body movements** take on different meaning depending on the culture. Some consider finger or foot pointing disrespectful (Asian), while others would consider vigorous handshaking as a sign of aggression (Native American) or a gesture of good will (Anglo American). Observe the client's interactions with others to determine what body gestures are acceptable and appropriate in his or her culture. When in doubt, ask.

Relevant Information on Specific Cultural Groups

Every community is unique. Even communities with a similar ethnocultural makeup may vary depending on geographic region, whether the community is in an urban or rural setting, or a host of other factors. Thus, there are no standard blueprints to address the needs of each ethnic community. One must work with the community to understand its values, attitudes, strengths, weaknesses, perceptions, and behaviors, and to learn how to work effectively within that context. There are, however, some general characteristics that can be used to describe particular cultural groups.

This chapter will discuss some cultural issues relevant to working with clients who are Amish, Asian American, Black American, Hispanic or Latino, and Haitian. Again, it cannot be emphasized too strongly that members of your community may or may not think, behave, or feel in the ways described for their ethnic group. The importance of conducting your own community assessment with the tools described in Chapter 3 and evaluating each client's cultural belief system using the tools described in Chapter 4 cannot be overstated.

There is always the danger of overgeneralizing or stereotyping when cultural information such as this is described. It is vitally important that none of these groups be seen as a monolith, but rather as a collection of individuals who share a common cultural heritage. There are many intragroup differences as well as intergroup dissimilarities and similarities. Please be aware of these caveats as you read and use the cultural information presented on the following pages.

■ ■ ■ Amish

> The cultural values and behaviors outlined below represent only some of the many possible variations that may exist within Amish cultures. In order to provide effective services to any community of people, service providers must learn about the cultural values and behaviors of the specific community and of individual clients.

The Amish do not keep precise records of their membership beyond the number of families in a district and the number of children in the schools. Therefore, the following figures represent an estimation of the Amish population. According to the *New American Almanac*, Amish directories, and correspondence with Amish informants provided by

Hostetler (1980), there were 526 districts of Amish with an estimated population of 85,783 in the United States in 1979. A breakdown by state indicates that, in that year, Ohio had an estimated Amish population of 29,137; Pennsylvania had 22,570; and Indiana had 16,628. Missouri, Iowa, and Wisconsin each had approximately 2,000, and Illinois, Michigan, and New York each had 1,000 Amish.

As in other populations, there are differences among individuals belonging to various Amish sects. The Old Order Amish are more traditional, while the New Order have made some changes to accommodate to modern society.

Old Order	New Order
Silent discourse	Verbal discourse
Emphasize keeping traditions of past -- separation, exclusion, avoidance.	Don't emphasize traditional ways of living, though they live by Amish customs. Separation means spiritual rather than physical.
Forbid ownership of field tractors, autos, electricity or telephones. Habitual use forbidden or discouraged. Emergency use is sanctioned.	Use of tractors allowed. Secularization in dress (more apparent in men than in women). Work in nearby towns or cities rather than farmwork for men. Women work as domestics in both Amish and other households.
Accept Biblical teachings unquestioningly.	Think, evaluate, and critically examine Biblical teachings.
German language used at home; English used with outsiders.	Mixture of English and German languages used.
Smaller communities -- mutual respect and sharing of risks and experiences.	Larger communities -- less personal contact and indifference to others one does not know.

Important cultural values and behaviors	Clinical application
Social Organization	
Congregation usually consists of 30-40 households living in close proximity. Most are related by marriage or blood line.	Realize that intermarriage may have impact on incidence of genetic disorders. Use family genealogies for identifying carriers and potential clients.

Strive for self-sufficiency, but are not economically self-sustaining. Dependent on local markets, merchants, hospitals, and medical services. Self-sufficient in religious life, socialization patterns, and educational functions.	Understand that Amish are not accustomed to dealing with outside world. Emphasize need for collaboration in therapeutic treatment plan.
Bishop is leader of congregation and chief authority.	Involve Bishop in counseling and education efforts.
Values include hard work, thrift, brotherly love, humility, and mutual aid. There is a repulsion of city ways, especially what is seen as nonproductive use of time, money, and energy.	Validate these values and employ them to further the goals of counseling and education.
Mutual aid of family and community members during times of stress, sickness, old age, or death.	Involve other community members in educational efforts.
Leisure activities include visiting, work bees, barn raisings, quiltings, and preparations for funerals and weddings -- all activities where work and pleasure are combined.	Utilize already assembled groups of community members for educational interventions.
Opposed to receiving direct government aid of any kind.	Emphasize independence of counseling and education program from government. Explore alternative means for financial aid for treatment.

Time Perception

Oriented to past, though live in the present.	
Keep "slow time" -- don't observe daylight savings time. When standard time is reinstituted, Amish set clocks one-half hour ahead.	Clarify with client which time will be utilized for clinic appointments.

Family

Family Structure

Large families (average number of children is 7) with three generations living in adjoining units. Family has authority over individual during childhood, adolescence, and later life.	Understand importance of family's influence and involve them in treatment plan when appropriate.
Strong ties maintained between generations; revere the elderly.	

Family Dynamics

Monogamy valued. No divorce. Quiet and sober relationship between husband and wife. No apparent displays of affection. Never disagree in public.	Don't mistake lack of disagreement during counseling of couples to mean no conflict exists. After rapport building, give permission to vent frustration and anger.
Patriarchal -- overall authority belongs to man. Woman is considered husband's helper, not his equal. Willing submission of wife to husband. Women have subordinate roles in religious life. At home they are responsible for cooking, sewing, gardening, cleaning, preserving food and caring for children.	Understand that although male is ultimate authority, women often have a great deal of influence in the health domain. It will be important to involve both in the treatment plans for all family members.
Parents obligated to aid children through adulthood by lending them money, visiting them frequently, and providing for their spiritual welfare.	
Children are valued. Older children care for and help younger children. Learn early about Amish way of life and to respect authority of parents. Schools teach children literacy, cooperation, and skills needed to live productive lives in keeping with values taught in home and school. Schooling through elementary years only.	Understand the importance of children to Amish community.
Adolescents belong to gangs of friends. Importance of peer group. Dating and courtship accomplished through Sunday evening sings where unmarried girls 14 to 16 and unmarried boys 16 and older socialize unaccompanied by adults.	Explore option of peer educators to deliver educational messages to adolescents.

Religion

Religion and custom are inseparable and blend into a way of life. Religious considerations determine hours of work, occupation, means and destination of travel, and choice of friends and mate.	Observe religious constraints when setting up meetings, workshops, and appointments.

Importance of working with elements of nature rather than mastery over them. Closeness to soil, animals, plants, and weather is valued. Salvation is viewed as obedience to the community.	Acknowledge these values and incorporate them into treatment plan. Emphasize duty to community to maintain good health.

Health and Illness

Very health conscious. Quick to recognize individuals who are sick or incapacitated. No stigma attached to being sick.	Enlist community support for emotional, physical, and financial needs of client and family.
Health is defined as having a good appetite, looking well, and engaging in rigorous physical labor.	Educate regarding other signs and symptoms of illness.
Belief that the human body was created by God and should not be tampered with. Medicine may help, but it is God who heals.	Emphasize importance of working with God to maintain health.
No Amish physicians. Nothing forbids Amish from using medical services, including blood transfusions, hospitalizations, or immunizations. Wary of accepting government-sponsored health plans.	Work with client and family to develop a treatment plan that emphasizes independence and autonomy while benefiting from current medical practices.
Rely on own tradition for diagnosing. Don't go to physician for minor illnesses because of time consuming trips due to transportation means.	Validate role of self care, but emphasize conditions under which outside help is indicated.
Mental illness is indicated by frequent visits to the doctor, failure to find full satisfaction in a day's work, rigidity of attitudes, and males who fail to marry. Depression is common, especially in women who have no outlet for anger and frustration. Persons encouraged to work rather than sitting around thinking about their problems.	Recognize this cultural definition of mental illness. Explore ramifications of these for persons with chronic illness or acute infections.
Folk healing includes traditional home remedies such as teas, tonics, salves, liniments, ointments, and poultices.	Work within this system when appropriate.

Sympathy curing, also called pow-wowing, is used to heal people and animals. Methods used include invoking chants, using charms and amulets, and engaging in physical manipulation. Other terms used are "charming," "conjuring," "to try for," and "to use." Two kinds of healers exist: practitioners who set up a treatment room and accept the role of doctor; grandmothers who are pressed into pow-wowing when all else fails. Patients may travel long distances to visit these healers.	Determine whether or not client feels that they have been hexed. Work with folk healers in cases where conjuring has occurred.

Sexuality

Traditionally oppose premarital and extramarital sex. Must confess to church assembly and are excommunicated. After repentance are allowed back into church and are completely forgiven.	Emphasize the confidentiality of the counseling relationship. Understand the cultural taboos, but be aware that there are differences between the real and the ideal.
Among some sects there are deviations from the norm. Premarital sex, tobacco smoking, and drinking often take place among adolescents in particular. While parents disagree, they usually turn the other way and dismiss these transgressions as temporary departures.	Give client permission to explore issues related to sexuality and other forms of behavior not sanctioned by the community. Offer a reality check regarding impact behavior will have within cultural context.
Prohibitions against birth control.	

■■■ Asian Americans

> The cultural values and behaviors outlined below represent only some of the many possible variations that may exist within Asian cultures. In order to provide effective services to any community of people, service providers must learn about the cultural values and behaviors of the specific community and of individual clients.

This generic term describes persons whose ethnic heritage is identified with China, Japan, Korea, Southeast Asia, and other Pacific Islands such as Samoa, Guam, and the Philippines. Provisional 1980 U.S. Census data indicate that there are approximately 3,501,000 Asian Americans living in this country, constituting approximately 1.5 percent of the total population.

This is a highly urban population: 46.4 percent live inside central cities and 45.0 percent live outside central cities but within Standard Metropolitan Statistical Areas (SMSAs). Only 8.6 percent live in non-urban locations. There is great ethnic diversity within the Asian American subculture. These differences are based on the following characteristics of the client:

- Nationality and heritage
- Social class and socioeconomic level
- Age
- Generation
- Urban/rural residence in Asia
- Education
- Length of time in this country

There are three modes of adaptation to American society:

1. Old-Line pattern -- hold tight to traditional values and practices, such as obedience to parents, respect for authority, self-control of strong feelings, humility, praise for others, blame of self for failure, and balance between Asian and Western healing traditions.

2. Assimilative pattern -- so eager to integrate into mainstream American life that they deliberately turn their backs on their own traditions and values. This pattern is one especially true for teenagers and children. Often, this pattern leads to an identity crisis. Values important to this group are: assertiveness, independence, self-confidence, individuality, and openness of expression.

3. Bicultural pattern -- preserve traditional values and beliefs while acquiring new values and practices necessary for successful life in a new society.

Generally, new immigrants would adhere to the first pattern, second or third generation Asian Americans would follow the assimilative mode, and those who have been in America the longest would fit the bicultural pattern.

A language barrier may exist which will require a translator or interpreter. Contact refugee sponsors, self-help groups, community

outreach programs, or private agencies working with Indo-Chinese refugees or other Asian groups to find a suitable person to fill this role. Use the guidelines in Chapter 5 to work most effectively with an interpreter.

Important cultural values and behaviors	Clinical application
Nonverbal Communication Styles	
Greetings: Women do not shake hands with each other or with men.	Be cautious about offering your hand first with a woman client or family member.
Traditional greeting is a "wai" -- a joining of hands, raised up to the chest, and head bowed slightly.	Greet clients in their cultural style to communicate an understanding of, and respect for, their culture.
Touching of strangers is inappropriate.	Be cautious about touching client. Communicate concern in other ways; offer tea, a symbol of friendship and goodwill.
Touching of head may be construed as an attempt to rid the spirit in some Asian groups. Indo-Chinese believe that the soul or spirit resides in the head.	Be cautious about touching the head of any member of the Asian culture.
Eye-to-eye contact between strangers is considered shameful.	Don't gaze steadily if the client appears to be uncomfortable. Asians are more comfortable with fleeting eye contact.
Pointing at things or people with one's toe is considered rude and disrespectful.	It is best not to cross your legs during counseling sessions to avoid pointing at client.
Waving arms, especially with palms facing upward, is considered a sign of contempt.	Try to avoid waving or pointing.
Individuals sometimes smile or laugh to mask other emotions or avoid conflict.	Don't assume smiling or laughing signals rapport or understanding. These behaviors may, in fact, signal just the opposite, i.e., disagreements, frustrations, confusion, or sometimes even anger.
Because Asians place a high value on emotional restraint, formality and politeness are essential.	Counselor should avoid a vivacious and highly casual manner, which may seem rude or make client feel uncomfortable.

Verbal Communication Styles

Verbally non-aggressive; self-deprecating.	Recognize this communication style as culturally determined and begin to encourage alternative styles of relating.
Nonconfrontational. To avoid confrontation, disrespect, disagreement, frustration, or even anger, Asians are indirect, indifferent, silent, or may smile reluctantly.	Counselor should be cautious in raising issues that appear conflictual or would evoke strong feelings. Client may withdraw or become depressed rather than angry.
Deference to others.	Encourage clients to see themselves as equal partners with therapist in treatment plan.
Noncommunicative of personal feelings since emotional expressions are seen as a sign of immaturity in Asian culture.	Encourage client to express feelings.

Views Toward Counseling

Mental illness is stigmatized, often considered a genetic trait and thus is a family secret not to be shared with outsiders. Family members are relied on for mental problems.	Extended time may be needed for therapy to encourage clients to express their feelings.
Personal problems are not to be discussed outside the family and only certain topics are to be discussed within the family.	Stress confidentiality of the counseling relationship.
Because mental illnesses are not socially acceptable, depression and stress are often manifested as physical complaints. Only if client is psychotic will hospitalization be suggested by family.	When client presents for counseling it will only be after considerable time and pain. Psychosomatic ailments might actually be the presenting complaint.
Client feels shame for needing help.	Counselor needs to self-reveal. This increases trust and signals that even though the therapist may have a different orientation and value system, he/she has experienced the same feelings and yearnings.

Expects counselor to know what is best and wants to be told what to do. Accustomed to accepting orders and directions from superiors. Own initiative is not valued.	Concrete, well-structured approaches are most useful in counseling. Directive rather than nondirective approach should be taken. Encourage client to begin to take initiative in making concrete changes.

Time Perception

Belief that time is flexible so there is no need to hurry or be punctual except in extremely important cases.	Acknowledge client/counselor differences in value placed on time and explain need to work within a schedule in order to be helpful and available to each client who needs your service. Emphasize importance of keeping scheduled appointments.
View American focus on time as offensive. Asians spend hours getting to know people and view predetermined, abrupt endings as rude.	Set up a more flexible time schedule rather than abiding by the traditional therapy "hour" or strict appointment times. Small talk at the beginning of a session will be considered good manners and keeps you from appearing too brusque or rushed.

Family

Great importance is placed on the family. The individual is primarily a member of the family.

Family Structure

Basic unit is extended family. Often 3 or 4 generations live together.	Involve extended family in treatment plan.
Patriarchal -- The senior male is the head of the household. He is expected to be teacher and role model. His authority is unquestioned. When talking to a family group it is proper to address the husband or oldest male first in deference to his position as head of the family. Bowing the head conveys respect to elderly. Asians defer to them because of their wisdom.	When talking to a family group, it is proper to address the husband or oldest male first in deference to his position as head of the family.

Relationships between the father and sons are especially emphasized.	Acknowledge importance of father-son relationship. Consider this relationship as both a strength and source of possible conflict. Understand the importance of the father-son relationship when counseling couples also.
The primary duty of the son is to be a good son through respecting his father and worshipping his ancestry. His obligation to be a good husband or father is secondary.	
The traditional role of females is to be subservient to men, perform domestic duties, and to marry and bear children (especially male children since sons traditionally are valued more than daughters).	Females may experience conflictual feelings between traditional roles and those of mainstream America. Encourage exploration of these feelings.
Child rearing usually is done by the mothers for the first two years, and then by the paternal grandmother.	Involve grandmother in treatment plan if client is a child or adolescent.
Parents are proud of having a large family. Children are important to the family because they represent the future of the families. As adults they are expected to bring reputation and wealth to their extended family.	If appropriate, acknowledge how difficult it will be to postpone having children. Suggest alternatives, such as adoption.
Children live with their parents until they marry. After marriage, the woman lives with the husband's family and belongs to that family.	Greater dependency on family than counselor might expect. Understand this cultural custom and help client resolve the conflict between this traditional custom and expectations of mainstream America regarding adolescent developmental processes. Acknowledge influence of parents and in-laws in decision making processes.
Family Dynamics	
Family members are expected to submerge their own behaviors and feelings in order to further the welfare of the family and its reputation.	Client may not be in touch with own feelings and will need counselor's help identifying what feelings exist and how they are alike or different from family's.
The family is responsible for all decisions so the behavior of an individual member reflects on the entire family. Behaviors that embarrass the individual lead to family shame. Thus, inappropriate behaviors are handled as much as possible within the family. They avoid public admission of problems.	Involve family in treatment plan. Help client individuate within context of strong family unit.

Shame and guilt collectively shared by the family, as well as feelings of inferiority for not reaching ideals and goals as defined by them.	
Dependency and conformity are prolonged within the family. If children attempt to act independently, they are chastised for being selfish and inconsiderate. They are taught to be cautious about initiatives and innovations.	Youth may appear timid, dependent, and cautious compared to other clients. May tell you what they think you want to hear. Encourage and reinforce independent actions.
Great respect given to learning. High educational standards.	Use this motivation to impart new information and encourage behavior change.

Health and Illness

Illness may result from bad conduct by an individual or family member in this or a previous existence.	Clients may feel personally responsible for their illness. Careful explanation of the etiology of illness may be necessary.
Everyone is expected to take responsibility for curing him/herself without complaint. Elderly particularly hesitant to seek outside help in health matters. Feel responsibility for welfare of others in family but not for those outside family system.	Client may be hesitant to admit health problem. Encourage client to share feelings about illness.
Health depends on maintaining a balance within the body between opposing forces of yin and yang. Strong emotions and improper diet can disturb this balance.	
All diseases as well as foods are classified by the hot/cold dichotomy. This classification varies by subgroup, yin-cold, yang-hot. Often try herbs, ginseng, self-restraint, acupuncture, meditation to help restore balance to the system. Often refrain from eating when ill or balance their diet according to the hot/cold theory.	Combine biomedical concepts and treatments with yin/yang system. Work within the yin/yang dichotomy to devise a culturally appropriate treatment plan. Prescribe "hot" medications for "hot" disease, and "cold" medications for "cold" diseases.

Sexuality

Members of the opposite sex do not touch in public. However, persons of the same sex may hold hands in public, sleep in the same bed, and are not considered homosexuals.	
Very modest	Respect this value during physical exams particularly.
Sex is treated more matter-of-factly than in many other cultures.	Same sex counselor can be most effective. Frank discussion of sexual matters is appropriate. There may be a lot of discomfort when talking with a counselor of opposite sex. This may take a longer rapport-building phase.

Religion

Buddhism intertwined with Confuscionism and Taoism. Belief in Karma -- theory that one's present life is predetermined by his/her good or bad deeds in a previous life.	Emphasize control individual has over Karma and quality of life in future reincarnations.
Belief in good and evil spirits that live in man and nature. When ill, a diviner may be consulted to determine what spirit is angry and what ceremony might appease it.	Ascertain client's perception of cause of illness. Work with traditional healers or diviners when appropriate.

Death

Belief in reincarnation.	Will be useful concept in counseling regarding poor prognosis.
Elderly want to die at home -- not in a hospital or elsewhere.	Respect this desire and arrange for dying at home.

■ ■ ■ Black Americans

> The cultural values and behaviors outlined below represent only some of the many possible variations that may exist within black cultures. In order to provide effective services to any community of people, service providers must learn about the cultural values and behaviors of the specific community and of individual clients.

Provisional 1980 U.S. Census data report that the approximately 26,48,000 blacks make up 11.7 percent of the total U.S. population. Among the surveyed minority groups, the black group has the greatest proportion (57.8%) living in a central city. Another 23.3 percent of blacks live outside a central city but within a SMSA. The remaining 18.9 percent of this population live in a rural setting. While the black population might appear on the surface to be more culturally homogeneous than the other target minority populations, there is much diversity in this population as well. Most members of this group are native-born Americans of African ancestry. However, in recent years there has been significant black immigration from several Caribbean countries. Because of their shared African roots, many black Americans -- whether native or foreign born -- share common beliefs, practices, attitudes and values. However, there are individual differences based on social class, country of origin, occupation, religion, socioeconomic status, educational level, urban or rural residence, and regional origin.

The principal stressors among black Americans are:

- Frustration from continuing discrimination and rejection.
- Urban migration and weakening of the family support network.
- Poverty and pressures of economic instability.
- Feeling trapped in what is perceived as an unchangeable life situation.
- Feelings of rage and worthlessness that are often dealt with through self-destructive behavior - violence, drugs, alcohol abuse, suicide.
- Weakening of traditional community and family ties which were so important in socializing children and coping with stress.
- Undocumented or illegal status of many immigrants, which impacts on their utilization of the health care system. They are not eligible for public health services; if their employers do not provide insurance, their access to health care is severely limited.
- Poor health including high rates of heart disease, certain kinds of cancer, diabetes, and AIDS.

Important cultural values and behaviors	Clinical application
Nonverbal Communication Styles	
Listening behavior -- tend to look at someone when they are talking and look away while listening. Prolonged eye contact is considered to be staring. May perform other activities; likely to nod their heads and make responses to indicate they are listening.	Understand these cultural differences so you do not misinterpret these behaviors as indifference. Avoid prolonged eye contact.
Body space -- blacks move in closer than whites when talking.	Understand these differences and allow client to define parameters of contact.
Views Toward Counseling	
Mental illness is seen as caused by: disturbances in interpersonal relations; demonic possession; brain injury.	Ask clients what they believe is the cause of the problem.
Counseling often viewed as a stigma, and threatening, so blacks don't often self-refer to mental health agencies. Presence in a mental health agency indicates problem is advanced and individual is at high risk.	Emphasize importance of seeking professional help when stressed or troubled.
Because blacks tend to rely on own resources in taking care of their problems, they may downplay severity of their problems and indicate that they have situation under control when, in fact, they do not.	Give client permission to have problems. Don't misinterpret a calm exterior or non-verbalization of stress to mean that there isn't any.
Client may, of necessity, be focusing on survival issues rather than psychological needs.	Acknowledge priorities of client. Help with meeting basic needs by referral to appropriate social service agencies. After survival needs are met, psychological services will be accepted as appropriate.
Quite reluctant to discuss family problems and personal relationships with outsiders.	May be helpful if counselor self-reveals a bit in order to establish rapport and trust.
Prefer action- and task-oriented counseling.	Provide immediate and specific solutions and advice with respect to client's problems.

Utilization of mental health agencies: middle-class and urban blacks are more likely to use mental health agencies for emotional problems than are lower socioeconomic and rural blacks, who are more likely to rely on family members, ministers, or root doctors for these problems. Many people use both the formal mental health system and the informal community system.	Refer to appropriate treatment facility or mental health worker. May need to work with minister or other identified helper in treatment plan.

Time Perception

Present oriented -- not preoccupied with future goals.	Discuss concept of prevention of chronic complications. However, focus on immediate situation rather than future plans.

Family

Family Structure

Extended family and kinship network are extremely important. Members are counted on for moral support, financial aid, and help in crises.	Involve extended family in treatment plan.
Flexibility of roles within the family -- so decision making may rest with either male or female head of household. Many female headed households.	Determine who the significant decision maker is and involve them in treatment plan.

Family Dynamics

Elderly members of the community are respected.	Address elderly by last name and title. Consider involving elderly in treatment, particularly the grandmother.
Mother's responsibility to identify problem and decide what to do. Seeking professional consultation depends on perceived severity of condition and belief that treatment would cure the problem.	Involve mother or mother figure in treatment. Address your concerns regarding treatment to mother as well as client.
Many adults are important in child rearing and influential in shaping the actions of young people.	When working with children, involve significant adults in treatment.

Children are socialized to keep cool under pressure and learn survival skills from their elders.	Encourage expression of feelings of stress.

Religion and Health -- Intertwined

Religion is an important aspect of life. It provides an oasis from daily struggles with life, poverty, and conflict. The black minister is an important influence in the Christian community. He usually knows the emotional and psychological make-up of his parishioners.	Determine the religion of the client and the attitude toward science and medicine espoused by that religion. Work within that belief system. Involve black minister in treatment plan when appropriate.
Fatalistic world view -- believe that life and death are predetermined.	Emphasize that individual has ability to help God in his plans for them.
Religious beliefs affect blacks' conceptions about illness and health.	Be aware that guilt may influence client's perception of illness. Help client identify causes of illness and the specific actions he/she can take.
Some illnesses, especially many emotional problems, are seen as punishment for disobeying God or as the devil's work. Other illnesses are believed to be caused by witchcraft or possession of evil spirits.	
-- Common terms for this occurrence are: Fixed; Mojoed; Hoodooed; Hexed; Rooted.	
-- "Crazy" behavior and seizures are thought to be a sure sign the person is rooted. These episodes are usually related to stress.	
-- Client will almost never volunteer the information that they have been hexed to an "outsider" but will usually respond to direct questions asked in nonjudgemental fashion.	Ask client if they believe the illness was caused by any of these means.
-- These illnesses can only be cured by counterattack with more black magic (performed by root worker) or by efforts of those who represent forces of good (spiritual healers or faith healers).	Ask family members and/or client if involvement of these healers would be helpful in this situation.

Folk medicine often exists alongside biomedicine. Blacks will often use herbal and home remedies, seek spiritual advisors, wear charms and other objects for protection against evil spirits, and engage in other rituals of healing.	Convey a nonjudgemental attitude and ascertain which practices are used by the client, unless they endanger the health of the user. Try to incorporate treatment suggestions into this ongoing system, i.e., by emphasizing the natural origin of medications and treatments that derive from naturally occurring substances.

Sexuality

Homosexuality is less tolerated in the black community than in the general population.	Client may not identify himself as homosexual but will, in fact, be engaged in sexual relationships with other men. Careful questioning, in a nonjudgemental manner, will be important to elicit this information.

■■■ Haitians

> The cultural values and behaviors outlined below represent only some of the many possible variations that may exist within Haitian cultures. In order to provide effective services to any community of people, service providers must learn about the cultural values and behaviors of the specific community and of individual clients.

The Haitian population represents a recently immigrated group that originated from a poor, rural background in Haiti. They left their homeland to escape political oppression and economic destitution. There will be cultural differences among Haitians depending on:

- When they immigrated and their immigration status (legal/illegal)
- Social class
- Educational level
- Residential background (urban/rural)
- Skin color

The principal stressors are:

- Poverty
- Unemployment
- Poor housing
- Racial discrimination
- Language barrier
- Loneliness
- Isolation from many close relatives and friends who are still in Haiti
- Lack of support system

Because of language differences, a translator or interpreter who can communicate in Haitian Creole may be necessary.

Those who have immigrated illegally avoid contact with governmental agencies and institutions for fear of being returned to Haiti. Work through Haitian community groups to reach these clients. Because they share an African heritage, there are many similarities among American-born blacks and Haitians.

The following include cultural values and beliefs that are specific to Haitians.

Important cultural values and behaviors	Clinical application
Family Structure	
Very family oriented. Mother is seen as stabilizing influence. Extended family members are also influential.	Need for mother to be involved in treatment plan as well as significant others in the extended family system.
The control of parents over children extends into adulthood and includes the selection of marriage mate and choice of occupation.	Importance of involving other family members even for older adolescent clients.
Parental authority is respected and usually accepted without question.	Recognize parental authority as important influence in client's situation.
Pressure on youth to do well to enhance family status.	Explore strategies to cope with these pressures, especially in combination with those imposed by chronic illness.
Haitian young people are in a transitional state. They want to recognize their Haitian roots by observing cultural traditions while at the same time they feel the pressure to "fit in" with the mainstream American culture. This has created a lot of stress and also has caused discomfort between these young people and their elders who hold tenaciously to "old Haitian ways" of living.	Recognize these conflicts and help youth adapt behaviors that incorporate aspects of both the "old" (traditional) and "new" (mainstream) ways.

Religion and Health and Illness

Personal fortitude valued -- illness is to be shared only with family and friends. Public display of weakness is discouraged. Client might be resistant to sharing thoughts regarding psychological distress with an outsider.	Treatment should include family members who can encourage the client to explore emotional problems and arrive at coping strategies.
Religious beliefs (voodoo) related to beliefs about health and illness. Illnesses are seen as natural and supernatural. Supernatural illnesses appear suddenly and are caused by evil spirits. These illnesses are believed to be cured only by a voodoo priest who mediates with the spirits on behalf of the individual in distress. There may be psychological or physical disturbances as a result of being possessed.	Ask client if feelings of distress relate to being hexed or possessed. If client believes he/she has been possessed by evil spirits or hexed by another individual, he/she will desire the intervention of a voodoo priest rather than a mental health professional to relieve the distress. It is possible for mental health professionals to work <u>with</u> voodoo practitioners but not <u>alone</u>.
Dreams are important events that allow the individual to communicate with inhabitants of the supernatural world. When dead relatives appear in a dream, they bring messages from the other world upon which the Haitian individual is likely to act.	Client may have gotten a message from supernatural world compelling him/her to engage in behavior which counselor identifies as harmful or self-destructive. Work with voodooist and family to help individual.
Blood is the medium of bodily and spiritual disease. The most dangerous types of illnesses are believed to be caused by irregularities in the blood system.	

Sexuality

Bisexuality is a very common occurrence among men.	Client may not readily offer this information. Counselor may need to elicit this information by asking if client has ever had sex with another man rather than using the labels of homosexuality or bisexuality. Be sensitive to client's feelings.

■ ■ ■ Hispanics/Latinos

> The cultural values and behaviors outlined below represent only some of the many possible variations that may exist within Hispanic/Latino cultures. In order to provide effective services to any community of people, service providers must learn about the cultural values and behaviors of the specific community and of individual clients.

"Hispanic" is a generic term that applies to a group of distinct subcultures. Some people prefer the term "Latino" because "Hispanic" takes into consideration only the language, and not the country of origin and shared cultural heritage.

Provisional 1980 U.S. Census data report that there are approximately 14,606,000 Spanish-speaking or Hispanic individuals in this country, making up about 6.4 percent of the total population. Approximately half (50.3%) of this group live inside a central city. Another 37.3 percent live outside an SMSA. This is a culturally diverse group, including people of Mexican ancestry, Cubans, Puerto Ricans in Puerto Rico, Puerto Ricans in New York and other U.S. continental locations, and people from many Central and South American countries.

Hispanics share many characteristics, values, traditions, and customs, yet there are important differences among and within specific Hispanic groups.

Differences among Hispanics are influenced by:

- Educational level
- Socioeconomic level
- Immigration status (documented/undocumented)
- Age
- Length of time in the United States
- Degree to which they have adopted Anglo behavior
- Rural vs. urban residence
- Country of origin -- historical, economic, and political experiences there

Particular stressors for many Hispanics, particularly recent immigrants from Mexico and Central America, include the fact that many are undocumented immigrants (popularly referred to as illegal aliens) and thus avoid contact with public programs for fear of being caught.

Important cultural values and behaviors	Clinical application
Nonverbal Communication Styles	
Hispanics tend to:	
-- touch people with whom they are speaking.	
-- sit and stand closer than Anglos.	Allow client to define body space parameters.
-- shake hands or engage in an introductory embrace, kissing on the cheek, back slapping.	Shake hands in greeting.
-- interpret prolonged eye contact as disrespectful.	Avoid prolonged eye contact.
-- expect elderly to be treated with respect.	Address elderly more formally than younger clients.
Verbal Communication Styles	
May have limited use and understanding of English.	Conduct session in Spanish or use an interpreter.
Hesitant to disclose personal or family information to a stranger.	An initial period of friendly, informal conversation or chatting before discussing problems often helps to avoid appearing unfriendly or discourteous.
Nonconfrontational.	Establish trust, support, warmth, and caring before dealing with difficult issues.
Females emotionally expressive but males do little emotional communicating.	Recognize these sex differences and adjust your counseling style accordingly.
Views Toward Counseling	
Low utilization of mental health services:	
-- Believe that the system is culturally insensitive.	Provide culturally appropriate care.
-- Believe services are organized and operated to serve middle-class Anglos.	Convey acceptance of clients through verbal and nonverbal means.

-- Live in rural areas and lack transportation to get to clinics.	Aid in lining up transportation services or take services to them in neighborhood clinics.
-- There is often an absence of Spanish-speaking therapists.	Have interpreter available.
-- Rely on folk healers for many emotional problems, because these healers are perceived as more effective than Anglo mental health workers.	Incorporate these healers into treatment when appropriate.
-- Mental illness implies stigma and loss of respect.	Reassure client regarding problems they are experiencing.
Prefer direct, tangible, and action-oriented approaches over introspective "talk and listen" methods.	Help clients define specific actions they can take to cope with their problem.
Males may be uncomfortable with female counselors because of traditional rigid sex-role expectations. However, homosexual or bisexual males may have difficulty discussing sexual problems with another male.	Team same-sex counselor with client if possible, except when counseling males regarding homosexuality or bisexuality.
Importance of extended family as support system.	Involve extended family in therapy.
Feeling of being outside mainstream Anglo society may be basis for many problems.	Work toward assigning clients to resolve conflicts by helping to clarify and understand their options within their cultural context.

Time Orientation

More concerned with the present than the future.	Focus on immediate solutions rather than long-term goals.
Polychronic time orientation -- engage in several things at the same time.	
Reputation for being late or on "Latin time" out of consideration for others who may not be ready.	Allow for more flexible time schedules for appointments.

Family

Family Structure

The strongest and most valued institution is the family, which includes the extended network of blood relatives, compadrazzo (close friends adopted as godparents), and in-laws. This respect for the traditional family is called familism. Function and responsibilities of the family include: financial and emotional support, care for elderly and ill, care and protection of the children, and a sense of belonging.	Involve significant members from the extended family in counseling or treatment plan. Female members of family play an especially important role in health matters and should be included.

Family Dynamics

Traditionally prescribed sex roles: Male -- head of household; dominant, authority figure; key decisionmaker in matters outside of the home; gives strength, honor and protection to female (machismo); disciplinarian, but few other responsibilities for child rearing.	Be aware of roles each plays when counseling couples. Any suggestions to break with traditional roles should be considered according to level of acculturation. Consider impact of chronic illness on male client with these cultural expectations.
Female -- nurturer, household responsibilities, child rearing and education, mediator between authoritarian father and the children.	
Elderly -- well respected, care for children and help in their rearing.	Address with respect and include them when possible in treatment plan.
Children -- considered a priority, parents make personal sacrifices for them, longer period of dependence on parents, older children expected to follow in parents' footsteps, consult parents for advice on important issues.	Respect youth's admiration of parents but encourage developmentally appropriate independent actions. Incorporate parents when possible in counseling.

Health and Illness and Religion Intertwined

Illness traditionally has its roots in physical imbalances or supernatural forces that include God's will, magical powers, evil spirits, powerful human forces, or emotional upsets.	Encourage clients to talk about why they feel they are "ill," "depressed," etc.

There is no differentiation between physical and emotional illnesses.	Client may present with physical complaints when, in fact, there is an emotional problem. Probe for cause of physical complaints.
There are a variety of healers in the Hispanic community -- Curandero (uses prayer, artifacts); Yerbero (herbalist); Espiritisa (practitioner of Espiritism, a religious cult concerned with communication with spirits and the purification of the soul through moral behavior); Santero (practitioner of Santeria, a religious cult concerned with teaching people how to control or placate the supernatural).	Involve the spiritual healers and priests in crisis intervention and therapy.
Fatalistic world view.	Explore ways clients can participate in determining their own fate.

Sexuality

Males are free to have extramarital affairs, females are not. Having women is necessary to identify as male.	Explore implications of this lifestyle for the transmission of HIV disease, such as AIDS or the HIV virus, to wife and other sexual partners.
Modesty is highly valued. Open discussions of sex are taboo.	Establish rapport, build trust, approach this topic sensitively.
Majority are sexually conservative.	Ascertain sexual practices in as nonthreatening a way as possible, *after* rapport has been built and trust established.
Homosexuality is not tolerated, so men who have sex with other men rarely identify themselves as bisexual or homosexual.	Any questions regarding sexual practices should avoid the labels of homo-/bisexuality.

Bibliography

Counseling Ethnic Minorities

Axelson, J. (1985). *Counseling and development in a multicultural society*. Monterey, CA: Brooks-Cole.

Bestman, E., Lefley, H., & Scott, C. (1976, March). *Culturally appropriate interventions: paradigms and pitfalls*. Paper presented at the 53rd Annual Meeting of the American Orthopsychiatric Association, Atlanta, GA.

Brown, P. A. (1976). Differential utilization of the health care delivery system by members of ethnic minorities. *Journal of Sociology and Social Welfare, 3*, 516-523.

Brownlee, A. (1978). *Community, culture and care: A cross-cultural guide for health workers*. St. Louis, MO: C.V. Mosby Company.

Brownlee, A. (1978b). The family and health care: Exploration in cross-cultural settings. *Social Work in Health Care, 4*, 179-198.

Clark, A. (Ed.). (1978). Cultural, childbearing, health professionals. Philadelphia: Davis.

Corner Drug Store. (1986). *Teen Suicide Prevention Computer Based Training and Reference Library*. Tulsa, OK: National Resource Center.

Foster, G. (1962). *Traditional cultures and the impact of technological change*. New York: Harper and Row.

Gaylen, W., Glasser, I., Marcus, S., & Rothman, D. (1975). *The limits of benevolence*. New York: Harper and Row.

Grasska, M., & McFarland, T. (1982). Overcoming the language barrier: Problems and solutions. *American Journal of Nursing, 82*(9), 1376-1379.

Harwood, A. (Ed.). (1981). *Ethnicity and medical care*. Cambridge, MA: Harvard University Press.

Heisenberg, W. (1974). *Across the frontiers*. New York: Harper and Row.

Henderson, G. (Ed.). (1979). *Understanding and counseling ethnic minorities*. Springfield, IL: Charles C Thomas.

Henderson, G., & Primeaux, M. (Eds.). (1981). *Transcultural health care*. Menlo Park, CA: Addison-Wesley Publishing Company.

Janosik, E. H. (1980). Variations in ethnic families. In J R. Miller & E. H. Janosik (Eds.), *Family Focused Care* (pp, 58-101). New York: McGraw-Hill.

Jenkins, R. (1988, April). *Organizing minority communities to combat AIDS.* Presented to the 15th Annual Regional Conference on Maternal and Child Health. Chapel Hill, NC.

Jenkins, S., & Morrison, B. (1978). Ethnicity and source delivery. *American Journal of Morrison Orthopsychiatry. 48,* 160-165.

Kumabe, K. T., Nishida, C., & Hepworth, D. H. (1985). *Bridging ethnocultural diversity in social work and health.* Honolulu: University of Hawaii School of Social Work.

Kleinman, A., Eisenberg, L., & Good, G. (1978). Culture, illness and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine, 88,* 251-258.

Lust, J. (1974). *The Herb Book.* New York: Benedict Lust.

Mendel, C. H., & Haberstein, R. W. (1976). *Ethnic families in America.* New York: Elsevier.

Orque, M., Block, B., & Monrroy, L. (1983). *Ethnic nursing care: A multicultural approach.* St. Louis, MO: CV Mosby Company.

Pederson, P., Draguns, J., Lonner, W., & Trimble, J. (1976). *Counseling across cultures.* Honolulu: University Press of Hawaii.

Putsch, R. (1985). Cross-cultural communications. *Journal of the American Medical Association, 254,* 3344-3348.

Roberson, M.H. (1987). Folk health beliefs of health professionals. *Western Journal of Nursing Research,* 9(2), 257-263.

Scott, C. (1974). Health and healing practices among five ethnic groups in Miami, Florida. *Public Health Reports, 89*(6), 524-532.

Sue, D. (1981). *Counseling the culturally different: Theory and practice.* New York: Wiley.

Tripp-Reimer, T. (1982). Barriers to health care: Variations in interpretation of non-Appalachian health professionals. *Western Journal of Nursing Research, 5*(2), 179-191.

U.S. Department of Agriculture/Department of Health & Human Services. (1986). *Cross-cultural counseling: A guide for nutrition health counselors.* Alexandria VA: U.S. Department of Agriculture (USDA)/Department of Health & Human Services (DHHS).

Amish

Armstrong, P., & Feldman, S. (1986). *A midwife's story*. New York: Arbor House.

Gingerich, O. (1972). *The Amish of Canada*. Waterloo, Ontario: Conrad Press.

Hostetler, J. (1980). *Amish society*. Baltimore: Johns Hopkins.

Huntington, G. (1976). The Amish family. In C. H. Mendel & R. W. Haberstein (Eds.), *Ethnic families in America*. New York: Elsevier.

Rice, C. S., & Steinmetz, R. C. (1956). *The Amish year*. New Brunswick: Rutgers University Press.

Smith, E. (1958). *The Amish people*. New York: Exposition University Press.

Smith, E. (1960). *Studies in Amish demography*. Harrisonburg, VA: Research Council, East Mennonite College.

Warner, J., & Denlinger, D. (1969). *The gentle people: A portrait of the Amish*. New York: Grossman Publishers.

Wittmer, J. (1970). Homogeneity of personality characteristics: A comparison between Old Order Amish and Non-Amish. *American Anthropologist, 72*, 1063-1067.

Asian-Americans

Khoa, L. X., Phan, D. T., Doeung, H. H., Chaw, K., Pham, P. G., Bounthinh, T., Vandeusen, J., & Miller, B. Southeast Asian social and cultural customs: Similarities and differences. *Journal of Refugee Resettlement*, 27-46.

Khoa, L. X., & Vandeusen, J. Social and cultural customs: Their contribution to resettlement. *Journal of Refugee Resettlement*, 48-52.

Fuller, J. (1986). *Health and social beliefs of one Vietnamese-American family*. Unpublished paper, University of Florida, College of Nursing.

McKenzie, J., & Chrisman, N. (1977). Healing herbs, gods, and magic: Folk health beliefs among Filipino-Americans. *Nursing Outlook*, *25*(5), 326-329.

Rosenberg, J.A. (1986). Health care for Cambodian children: Integrating treatment plans. *Pediatric Nursing*, *12*(2), 118-125.

Santopeitro, M., & Smith, C. (1981). How to get through to a refugee patient. *RN Magazine*, 43-48.

Sue, D. (1981). Cultural and historical perspectives in counseling Asian Americans. In D. Sue (Ed.), *Counseling the culturally different: Theory and practice*, (pp. 113-140). New York: Wiley.

Toupin, E., & Ahn, S. W. (1980). Counseling Asians: Psychotherapy in the context of racism and Asian-American history. *American Journal of Orthopsychiatry*, *50*(1), 76-86.

Vandeusen, J., Coleman, C., Khoa, L. X., Phan, D., Chaw, H., Nguyen, L. T., Pham, P., & Bounthinh, T. Southeast Asian social and cultural customs: Similarities and differences. Part 1, *Journal of Refugee Resettlement*, 20-39.

Black-Americans

Dennis, R., & Kirk. A. (1976). Survey of the use of crisis intervention centers by the black population. *Suicide and Life Threatening Behavior*, *6*(2), 101-104.

Hill, R. (1972). *The strengths of black families*. New York: Emerson Hall.

Jackson, J. (1981). Urban black Americans. In A. Harwood (Ed.), *Ethnicity and medical care* (pp. 37-129). Cambridge, MA: Harvard University Press.

King, J. (1979). African survivals in the black American family: Key factors in stability. In G. Henderson (Ed.), *Understanding and counseling ethnic minorities*., (pp. 43-59). Springfield, IL: Charles C Thomas.

Kuna, R. (1977). Hoodoo: The indigenous medicine and psychiatry of the black American. *Mankind Quarterly*, *18*(2), 137-151.

Lowery, E. (1987). AIDS and the black community. Southern Christian Leadership Conference/W.O.M.E.N. Atlanta, GA: BAC Printing Co.

Randall-David, E. (1985). *"Mama always said": The transmission of health care beliefs among three generations of rural black women*. Doctoral Dissertation, University of Florida, Gainesville.

Smith, E. (1981). Cultural and historical perspectives in counseling blacks. In D. Sue (Ed.), *Counseling the culturally different* (pp. 141-185). New York: Wiley.

Straight, W. (1983). Throw downs, fixin, rooting and hexing. *Journal of Florida Medical Association*, *70*(8), 635-641.

Tingling, D. (1967). Voodoo, rootwork, and medicine. *Psychosomatic Medicine*, *29*(5), 483-490.

Walter, D. (1986). AIDS in the black community. *The Advocate, 2*, 10-11, 20-21.

Weintraub, R. (1973). The influence of others: Witchcraft and rootwork as explanations of behavior disturbances. *Journal of Nervous and Mental Disease, 156*(2), 318-326.

Haitians

Bestman, E., Lefley, H., & Scott, C. (1976, March). *Culturally appropriate intervention: Paradigms and pitfalls*. Paper presented at the 53rd Annual Meeting of the American Orthopsychiatric Association, Atlanta, GA.

Laguerre, M. (1981). Haitian Americans. In A. Harwood (Ed.), *Ethnicity and medical care* (pp. 172-210), Cambridge, MA: Harvard University Press.

Scott, C. (1973, November). *Haitian blood beliefs and practices in Miami, Florida*. Paper presented at the American Anthropological Association Meeting. New Orleans, LA.

Hispanics/Latinos

Ruiz, R. (1981). Cultural and historical perspectives in counseling Hispanics. In D. Sue (Ed.), *Counseling the culturally different: Theory and practice* (pp. 186-215). New York: Wiley.

Ruiz, R. A., & Padella, A. M. (1977). Counseling Latinos. *The Personnel and Guidance Journal, 55*, 401-408.

Cuban Americans

Sandoval, M. (1977). Afro Cuban concepts of disease and its treatment in Miami. *Journal of Operational Psychiatry, 8*(2), 52-63.

Sandoval, M. (1979). Santeria as a mental health care system. *Social Science and Medicine, 138*, 137-151.

Sandoval, M.(1983). Santeria. *Journal of the Florida Medical Association, 70*(8), 620-628.

Mexican-Americans

Aquilar, I. (1972). Initial contacts with Mexican-American families. *Social Work, 17*(3), 66-70.

Clark, M. (1959). *Health in the Mexican-American Culture: A Community Study.* Berkeley: University of California Press.

Clark, M. (1979). Mexican-American family structure. In G. Henderson (Ed.), *Understanding and counseling ethnic minorities* (pp. 123-137). Springfield, IL: Charles C Thomas.

Schreiber, J., & Homiak, J. (1981). Mexican Americans. In A. Harwood (Ed.), *Ethnicity and Medical Care* (pp. 264-335). Cambridge: Harvard University Press.

Puerto Ricans

Christensen, E. W. (1977). When counseling Puerto Ricans. *Personnel and Guidance Journal, 55*, 412-415.

Christensen, E. W. (1979). Counseling Puerto Ricans: Some cultural considerations. In G. Henderson (Ed.), *Understanding and Counseling Ethnic Minorities* (pp. 269-279). Springfield, IL: Charles C Thomas.

Delgado, M. (1979). Puerto Rican spiritualism and the social work profession. In G. Henderson (Ed.), *Understanding and Counseling Ethnic Minorities* (pp. 216-231). Springfield, IL: Charles C Thomas.

Harwood, A. (1981). Mainland Puerto Ricans. In A. Harwood (Ed.), *Ethnicity and medical care* (pp. 397-481). Cambridge, MA: Harvard University Press.

Native Americans

Kunitz, S., & Levy, J. (1981). Navajos. In A. Harwood (Ed.), *Ethnicity and medical care* (pp. 337-397). Cambridge, MA: Harvard University Press.

Primeaux, M. (1977). Caring for the American Indian patient, *American Journal of Nursing, 77*, 91-96.

Red Horse, J., Lewis, R., Feit, M., & Decker, J. (1978). Family behavior of urban American Indians. *Social Casework, 59*, 67-72.

Richardson, E. (1981). Cultural and historical perspectives in counseling American Indians. In D. Sue (Ed.), *Counseling the culturally different* (pp. 216-255). New York: Wiley.

Trimble, J. (1976). Value differentials and their importance in counseling American Indians. In P. Pederson, J. Draguns, W. Lonner, & J. Trimble (Eds.), *Counseling across cultures* (pp. 201-226). Honolulu: University Press of Hawaii.

Guidelines for Analysis of Sociocultural Factors in Health

The following guidelines have been excerpted from a manual of the same name as this Appendix, developed by the Office of International Health, Public Health Service. The material selected includes a broad range of sociocultural, psychological, and behavioral guidelines for assessing medical systems within different cultural contexts. A working knowledge of sociocultural factors that affect health is an essential tool for health educators and educators in general. The following "Assessment Questions" are offered in the spirit of promoting better cross-cultural understanding.

■ ■ ■ Assessment Questions

The Meaning of Health in a Community

- What do people in the community generally consider a state of "wellness," "good health" to consist of? A state of "illness" or "poor health" to consist of?
- What conditions of the body are considered normal and abnormal?
- Do these definitions vary with different groups within the community?
- What do people want out of life?
- When is life worth living?
- When does it become better to die?
- What priority does the value of "good health" have within the community?
- Where does "good health" fit within the hierarchy of values or goals in the community?
- What general changes in the quality of life do individuals or groups in the community desire, if any?
- How can health related changes fit in with these general goals?
- What beliefs do people have concerning the organs and systems of the body and how they function?
- What are people's beliefs concerning "prevention of illness?"
- Do they feel it is possible? In what types of cases?
- Are there any particular methods people use to help maintain their own health or that of others?
- What are people's attitudes toward vaccinations, immunizations, various screening tests, and other preventive health measures?

- Are illnesses within the culture divided into those considered "physical" and "mental" (or "emotional")?
- If so, which illnesses are considered to be physical and which mental? Which a combination of the two?
- What types of mental illness, if this is a category used within the culture, are generally thought to exist by various members of the community?
- Are there any conditions that may be considered "mental illness" by outsiders, but which community members feel are normal?
- What mental illnesses identified by Western medical science are common or of importance in the area?
- Do various members of the community have knowledge of the occurrence of each of these illnesses, either by name or symptoms?
- Are any "diseases" of malnutrition common in the local area?
- Who is affected?
- What are the local beliefs about the causes of these diseases? Possible prevention and treatment?

The Meaning of Mental Health

- What is its traditional or local name (if any)?
- What is its Western medical name (if any)?
- What are its symptoms? Its cause(s)?
- What type(s) of person(s) does the mental illness usually affect?
- Can it be prevented, and if so, how?
- How is it diagnosed? Treated? Cured?
- What types of practitioners or other individuals are best able to prevent, diagnose, and/or treat the mental illness?
- What methods are generally used by each?
- What are the typical attitudes toward this mental illness and the person who has it?
- Are there any special taboos or other beliefs connected with the mental illness?
- In situations in which members of the community have recently migrated from another cultural area, is mental illness caused or influenced by the cultural conflicts experienced during the period of readjustment?
- To what extent has this been a factor in the illnesses of particular immigrant patients?
- What are the typical community attitudes toward mental illness?

- How are the mentally ill treated and cared for by their families? Others in the community?
- What are the attitudes of community members toward receiving various types of help for their mental or emotional problems?
- Are certain types of treatment more acceptable within the culture? More likely to be successful?

The Medical Belief System

- What general beliefs do various community people have concerning cause, prevention, diagnosis, and treatment of disease?
- Are there any special "theories of disease" to which certain people adhere?
- What is the general understanding of and attitudes toward Western medical explanations and practices?
- What specific types of disease or sickness are traditionally thought to exist by various members of the community?
- What diseases identified by Western medical science are common or of importance in the area?
- Do various members of the community have knowledge of the occurrence of each of these diseases either by name or symptoms? For each disease identified by community members:
  - What is its traditional or local name (if any)?
  - What is its Western medical name (if any)?
  - What are its symptoms? Its cause(s)?
  - What type(s) of person(s) does the disease usually affect?
  - Can it be prevented, and if so, how?
  - How is it diagnosed? Treated? Cured?
  - What types of practitioners or other individuals are best able to prevent, diagnose, and/or treat the disease?
  - What methods are generally used by each?
  - What are the typical attitudes toward this disease and the people who have it?
  - Are there any special taboos or other beliefs connected with the disease?
- What types of accidents are common in the local area?
- Who typically has various accidents? When? Where?
- What beliefs are common concerning the causes of various types of accidents? Their prevention?
- How are various injuries treated?

- What types of physical abnormalities or deformities are common within the local area?
- What types of physical conditions do the local people consider to be abnormal or deformed?
- What do people feel may be the cause of various abnormalities or deformities?
- Do people believe various abnormalities can be prevented? If so, how?
- What types of treatment are common?
- What types of efforts are made toward rehabilitation, if any?
- What are the typical attitudes toward persons deformed or handicapped in various ways?
- Are they treated in any way differently from other members of the community?
- What are the attitudes of persons of various ages, sexes, ethnic groups, and religions about the body? About discussion of the body? About self examination?
- What areas of the body are considered private?
- What are the local attitudes about display of various parts of the body?
- Are there any taboos or restrictions on who can see a woman's or man's body?
- What are the consequences of violations of the taboo?
- What remedies or rituals should follow violation of the taboo, if any?
- What are attitudes toward examination of the body by medical personnel (of various sexes, ages, statuses)?
- Do feelings of modesty make certain patients uncomfortable or embarrassed in certain medical situations?
- What might the health worker do to lessen embarrassment?

Beliefs about Death and Dying

- What are local attitudes and practices surrounding dying?
- Are there any special omens or signs portending death?
- Are special measures taken to ward off death?
- Where and how do people want to die?
- Are there types of death or places one might die that are particularly feared or disliked?
- What roles do various family and community members play when various persons are dying?
- Are any special rituals or ceremonies performed when someone is dying?

- What happens when various persons die?
- What are the practices concerning mourning, preparation of the body, the funeral, and burial?
- Do they vary depending on the age, sex, religion, ethnic group, or social status of the deceased?
- Are there any later observations of the death or further rites connected with it?
- When family and/or friends receive news of a death, how do they react?
- How is grief manifested within the culture?
- What are the usual ways of dealing with grief?
- What role should a friend, health worker, or others play in case of a death? When, if ever, does one offer condolences? What other actions may be expected?
- How do people normally feel about the subject of death?
- Are there any special taboos concerning death (mention of death or the dead; contact with the dead body, the place of death, or the deceased's possessions)?
- Are the dead believed to have any influence on those still living?
- How does (or should) beliefs about death and dying affect health program routine?
- What roles do family, friends, and others like to play during the death of a family member in a health facility?
- How may attitudes toward death affect the functioning of local health program workers?

Family and Personal Hygiene

- What are people's beliefs and attitudes concerning the benefits of various hygienic practices? Their possible effect on health?
- How may living conditions and resources available in the area influence habits of personal hygiene?
- What would be the attitudes of various types of people toward possible changes in hygienic practices?
- What are local attitudes and practices concerning washing various parts of the body?
- Washing clothes?
- Caring for the teeth?
- Wearing shoes?
- Are there any problems of body pests or parasites?
- What is done about them?

- Which hygienic practices promoted either by the outside health worker or the local culture seem to have a real effect on health?

Attitudes about Pregnancy and Childbirth

- How does a woman determine she is pregnant?
- Do women of various groups follow any special practices during pregnancy? Follow any special taboos? Eat or not eat certain foods? Follow any rituals?
- Take any special treatments or medicines?
- Change sexual practices?
- Change work patterns?
- Are certain conditions recognized as dangerous during pregnancy? What is done about them?
- What sources of advice and care are sought during pregnancy?
- Are certain traditional or Western health practitioners consulted by various women during pregnancy? Who are they? What do they do?
- Are there any special beliefs concerning forces (both animate and inanimate) that may have an influence on an unborn baby?
- What effects may these forces have?
- Is protection of any kind sought against forces that may be harmful?
- What are considered abnormal signs during pregnancy? Why?
- What is done about them?
- In what settings do various women in the community give birth?
- Who is present during the delivery in each setting and what role does each person play?
- What methods of delivery are used?
- What sanitary precautions are taken?
- What methods are used to cut and treat the umbilical cord?
- What is done with the placenta?
- What is done when various complications arise?
- Are any special customs or rituals followed concerning delivery or birth?
- Are there any special attitudes toward or customs concerning twins? Multiple births?
- What is done in the case of maternal or infant death during childbirth?

- What if the baby is born dead?
- Is infanticide practiced?
- In what types of cases?
- Does a child's sex make a difference?
- What are the local attitudes toward this practice?

Attitudes about Child Care

- Do mothers follow any special practices after the birth of a child?
- Change work schedules in any way?
- Change eating habits?
- Take any special medicines?
- Perform or take part in any special rituals or ceremonies?
- Go through a period of confinement?
- How do mothers and/or other relevant persons care for infants and children of various ages?
- How are infants and children cleaned? Fed? Watched? Toilet trained? Disciplined? Taught various skills? Cared for when ill?
- What happens if the mother is working? Ill? Absent? Dead?
- Who babysits for the mother? In what circumstances?
- Are there any child care practices hazardous to the health of the child?
- How is food allocated in families where it is scarce?

Sexual Behavior

- How is knowledge concerning sex acquired by growing children?
- What are the attitudes toward sex education of various types?
- How easily will various people discuss sexual topics?
- Is male or female circumcision practiced? Why? At what age?
- What methods and rituals (if any) are followed?
- Does the procedure ever cause infection or other harm to the health of those circumcised?
- What are the social and cultural beliefs and practices concerning menstruation?
- Are there any special rites, rituals, or taboos that must be observed during this period? Special measures to relieve cramps or problems of irregularity?

- What are the social and cultural beliefs and practices surrounding sexual intercourse (premarital sex play, obtaining a lover, techniques of coitus, reasons for intercourse, sexual restrictions or abstentions, extramarital intercourse, sexual aberrations in adulthood, concealments of the sexual organs, etc.)?
- What are the social and cultural beliefs and practices surrounding conception (theories of conception, development and feeding of the fetus, determining the sex of the offspring, barrenness and sterility, etc.)?
- How is menopause experienced within the culture?
- What are its symptoms?
- What meaning does it have?
- Are there special cures for related problems?
- What forms of homosexuality and bisexuality are common within the culture, if any? What are local attitudes toward homosexuality? Bisexuality?

Understanding the Psychological and Sociocultural Make-up of a Community

- What is the history of the community?
- Where does their culture come from?
- What is the basic world view? How was the earth created and who or what maintains the earth and all power within it?
- To what extent is the world view influenced by religion?
- What are the major religious groups in the community?
- Are there certain religious groups that may be difficult to identify because they operate in secret?
- For each religious group:
  - How is it organized?
  - Who are its members within the community?
  - The size of membership?
  - Requirements for membership?
  - Social characteristics of the members2 (sex, age, social class, etc.)?
  - What are the group's general beliefs, values, and practices?
  - Does the religion have any organized theology?
  - What role does the group play in overall community life?
  - What is the general history of the group and its role in the community?
- Who are the leaders of the religious groups within the community?
- What roles do they play within their religious group and the wider community?

- How do the various religious groups relate to each other?
- What conflicts exist?
- Areas of cooperation?
- How much overlap is there between the systems of religion and medicine within the community?
- What involvement do various religious groups and their leaders have in the area of health and illness?
- Do the religious groups hold special beliefs concerning what or who causes various illnesses and whether and how these illnesses can be prevented, diagnosed, or treated?
- The cause(s) of death and whether and how death might be prevented?
- Do any of the leaders or followers in the religious groups play roles in the prevention, diagnosis, and/or treatment of illness?
- How do the religious groups in the community affect the secular practice of medicine?
- How do they affect the health beliefs and practices of their followers?
- How do they affect the utilization of health care facilities?
- How do they affect the organization and practice of medical care?
- Do any of the beliefs and practices of various religious groups conflict with the philosophy or procedures of the health program?
- Should any special effort be made to discourage religious beliefs or practices that may be detrimental to health?
- Do any of the religious beliefs and practices of various religious groups complement each other?
- What rituals and ceremonies are observed by each religious group in the community?
- Are there religious rituals or ceremonies marking stages in the life cycle such as birth, entrance into adulthood, marriage, and death?
- Are there certain general rituals or ceremonies observed by all or part of the religious community?
- What are the major events in the "church calendar?"
- Who participates and how?
- Do some of these rituals or ceremonies affect the health or health care of the religious group's members?

- How could the operation of the health program be adapted to take account of important rituals and the needs of patients or other community members participating in them?
- Is the health program or other health facilities operated or strongly influenced by certain religious groups?
- To what extent does religious affiliation influence the type of care given? To what extent does religious affiliation affect the type of clientele that will use a particular facility?
- What is the attitude of the government and local community toward religiously affiliated health facilities?
- Do governmental and community attitudes affect the delivery of health care in these organizations?
- What is the religious background and/or current religious affiliation of health program workers?
- How does it influence their work?
- Are there religious obligations that may interfere with a health worker's job?
- Are there religious attitudes that may influence the care a worker gives patients?
- Should any adaptations be made within the health program to accommodate religious obligations, beliefs, and practices of the health workers themselves?
- What are the current relationships between various health workers and religious leaders and healers?
- Could these relationships be improved?
- Could (and should) various religious leaders and healers be involved in health program activities? Would they be willing to use their influence in ways that might benefit the health program?
- Are there any current conflicts between religious groups that would affect how the health program should relate to various religious leaders and their groups?

Understanding Behavioral Factors

- What indications may the people give of fear, pain, discomfort, etc.?
- How do patients' and community members' nonverbal gestures and their facial and body expressions vary from those to which health workers are accustomed?
- What is the meaning of silence in various situations?
- How is one expected to act in various types of silence?
- How do members of the culture typically use their language when trying to persuade or explain things to others?

- Do they use logical explanations, stories, or proverbs? Hold debates? Appeal to certain values?
- Could the health worker use similar techniques when communicating with patients or other community members?
- How can health-related explanations be adapted so they will be related to things people are familiar with in daily life?
- How does one show disapproval? Disagreement? Frustration? Is direct criticism and complaint accepted within the culture?
- If not, what ways are culturally accepted for expressing negative feelings?
- How is affection displayed? What about anger, embarrassment, and other emotions?
- When can various emotions be displayed, and with whom?
- What are the cultural norms concerning raised voices, arguments, sarcasm, swearing, expression of humor, etc.?
- How are "calls for help" (especially medical help) made within the culture?
- What signs (besides the verbal ones) do people give when they feel they need treatment?

Understanding Your Role as an Investigator

- What are your own attitudes, beliefs, and practices concerning health, illness, and medical care? (Answer for yourself and your culture the questions that have been posed in this manual.)
- Examine your beliefs and practices. Which seem scientifically justified and which seem simply a part of your "cultural baggage" and not useful or desirable within the local culture?
- What areas of agreement and disagreement can you find between your attitudes, beliefs, and practices and those of other health program workers or community members and patients?
- Do certain areas of disagreement or conflict cause problems within the program?
- These same questions should be applicable to professionals and administrators. Ultimately we must ask how should change take place.
- Is the culture one in which things are changing fast, or one in which things pretty much stay the same?
- Has the rate of change varied in recent times?
- What is the culture's view concerning the desirability of change?

- Are the people change-oriented, or do they tend to be conservative and tradition-minded?
- How is the general orientation toward change likely to affect efforts to promote changes in health beliefs and practices?
- What changes in health beliefs and practices do the people themselves want?
- What beliefs and practices in the health area are beneficial to health? Have no effect on health? Are harmful to health? Should harmful beliefs and practices be changed?
- What are the functions of various health beliefs and practices?
- How are various beliefs and practices linked to one another?
- What meaning do they have to those who practice them?
- Do the individual beliefs and practices link together to form a meaningful whole?
- Are suggestions for changing of certain health beliefs and practices realistic, considering the total situation? What is the place of the belief or practice within the culture?
- What effects or repercussions may certain changes in health beliefs and practices have in other areas of life?
- When proposing changes in health beliefs and practices, is it possible to develop innovations that fit in easily with the existing culture? Emphasize continuity with old traditions?
- If certain health beliefs and practices are influenced by religion, will this affect the ease with which they might be changed?
- What changes might be expected in the organization and influence of various religious groups in the community?
- What might be the effect of these changes on health and health care?

Understanding How the Community Operates

- How does information usually spread from one place to another within the community?
- What are the important formal channels of communication?
- The important informal channels?
- Who do the channels reach and how effective are they?
- What are the patterns of interaction within the community?
- Where do people usually gather or get together? Are these important places of communication?
- Who are the important opinion leaders and "communicators" within the community?
- Who has the greatest authority in the health area?

- Why are various leaders influential?
- What effect does the authority of various leaders have on the acceptance of their messages?
- What channels of communication do these leaders use?
- What channels of communication between the health program and community are currently being used? Are there certain difficulties that might be traced to lack of effective communication in some fields? Are there segments of the population that are not being reached?
- Could other means of communication be developed and used?
- Is there an active grapevine between the program and community?
- Can distortions be minimized by better communication at certain points?
- Could certain channels of communication already in operation within the community be used by the health program itself?
- Would certain community leaders and other communicators be willing to transmit messages between the program and their constituents?

Understanding the Relationship Between the Community And the Health and Education Program

- What are the attitudes of outside staff toward local community members and patients?
- What are the community's and patient's attitudes toward staff members coming from outside the local area?
- Does it vary with the area from which the worker comes? With the worker's position? Personality?
- How does the population feel in general toward outsiders and foreigners?
- How may this affect their specific attitudes toward the health worker?
- What might be the reasons for their feelings?
- How long do outside staff members usually remain in their positions in the local health program?
- Are there any difficulties in community and patient relations caused by the short-term nature of some of the contracts?
- Do the outside health workers' life-styles and physical living conditions tend to integrate or separate them from the local community?
- Should any changes be made?

- How will attempts by outside staff members to adjust to or imitate local behavior patterns be seen by the local population?
- To what extent should outsiders try to adopt or at least show appreciation of local customs?
- How do community people, patients, and staff make their opinions about the health program known?
- How are suggestions and complaints registered and dealt with?
- If the present system is inadequate, what new ways to handle suggestions and complaints could be developed?
- Do certain complaints mask hidden areas of concern? What can be done about the underlying causes of difficulty?

Possible Program Problems

- What community members are ignored by the services?
- Do certain people act as "gatekeepers," controlling communication within the program between patients and staff?
- How does information have to be altered if focused at various levels within the population?
- Are there traditional channels of communication through which information flows from the leaders down to the population and is simplified in the process?
- Could the health worker employ any of these channels?
- Are there any problems between staff that arise because of racial prejudice or discrimination?
- What is health program policy toward the hiring of various ethnic groups?
- Within the health program itself, what percentage of various ethnic or national groups are in positions of power and authority?
- What may account for differences?
- Are changes needed?
- What techniques might be used within the health program to begin working on problems of racial prejudice and discrimination among the staff itself?
- With what community groups or persons can the health worker communicate most easily? Least easily?
- Do tendencies to interact with certain people more often cause distortions in the way in which the health worker perceives the community? How can distortions be lessened?
- What means of communication are currently being used between staff and patients within the health program?

- Is communication adequate? If not, what adjustments might be made?
- Are there ways to check for areas where understanding is poor and eliminate them?
- Can you identify possible barriers to effective staff-patient communication within the program? (Barriers that may be due to differences in cultural beliefs, practices, and values or differences of social and economic status, education, sex, or age.) What might be done to overcome these barriers?
- Do any typical difficulties seem to arise between workers of differing age, sex, religious affiliation, education, health program status, or health discipline?
- Do any difficulties arise because workers of various cultures have differing attitudes on roles workers should play (i.e. roles workers of different ages or of different sex should play)?
- Are there any basic clashes of personality between staff members? What seem to be the causes of disagreement or dislike?
- What can be done to emphasize or broaden positive aspects of staff interrelations and lessen difficulties and misunderstandings?
- What means of communication are currently employed between staff members within the health program?
- Is communication adequate? If not, what new means for facilitating communication might be used?
- What means of communication between the health program and its sponsoring and/or supervising organization(s) are currently being used?
- How effective is communication?
- If poor, how could it be improved?

Bloch's Ethnic/Cultural Assessment Guide

From Orque et al. (1983, pp. 63-69).

Data Category	Guideline questions/instructions	Data Collected
CULTURAL		
Ethnic origin	Does the patient identify with a particular group (e.g., Puerto Rican, African)?	
Race	What is the patient's racial background (e.g., black, Filipino, American Indian)?	
Place of Birth	Where was the patient born?	
Relocations	Where has he lived (country, city)? During what years did patient live there and for how long? Has he moved recently?	
Habits, customs, and beliefs	Describe habits, customs, values, and beliefs patient holds or practices that affect his attitude toward birth, life, death, health and illness, time orientation, health care system, and health care providers. What is degree of belief and adherence by patient to his overall cultural system?	
Behaviors valued by culture	How does patient value privacy, courtesy, respect for elders, behaviors related to family roles and sex roles, and work ethic?	
Cultural sanctions and restrictions	Sanctions -- What is accepted behavior by patient's cultural group regarding expression of emotions and feelings, religious expressions, and response to illness and death?	

	Restrictions -- Does patient have any restrictions related to sexual matters, exposure of body parts, certain types of surgery (e.g., hysterectomy), discussion of dead relatives, and discussion of fears related to the unknown?
Language and communication process	What are some overall cultural characteristics of patient's language and communication process?
Language(s) and/or dialect(s) spoken	Which language(s) and/or dialect(s) does patient speak most frequently? Where? At home or work?
Language barriers	Which language does patient predominantly use in thinking? Does patient need bilingual interpreter in client-professional interactions? Is patient able to read and/or write in English?
Communication process	What are rules (linguistics) and modes (style) of communication process (e.g., "honorific" concept of showing "respect or deference" to others using words only common to specific ethnic/culture group)?
	Is there need for variation in technique of communicating and interviewing to accommodate patient's cultural background (e.g., tempo of conversation, eye or body contact, topic restrictions, norms of confidentiality, and style of explanation)?
	Are there any conflicts in verbal and nonverbal interactions between patient and professional?
	How does patient's nonverbal communication process compare with other ethnic/cultural groups, and how does it affect patient's response to health care?
	Are there any variations between patient's interethnic/interracial communication process or intracultural/intraracial communication process (e.g., between ethnic minority patient and white middle-class professional, or

	ethnic minority patient and ethnic minority professional; beliefs, attitudes, values, role variations, stereotyping [perception and prejudice])?
Healing beliefs/ Cultural healing system	What cultural healing system does the patient adhere to (e.g., Asian healing system, Raza/Latina Curanderismo)? What religious healing system does the patient predominantly adhere to (e.g., Seventh Day Adventist, West African voodoo Fundamentalist sect, Pentecostal)?
Cultural health beliefs	Is illness explained by the germ theory, presence of evil spirits, imbalance between "hot" and "cold" (yin and yang in Chinese culture), or disequilibrium between nature and man? Is good health related to success, ability to work or fulfill roles, reward from God, or balance with nature?
Cultural health practices	What types of cultural healing practices do the patient practice? Does he/she use healing remedies to cure *natural* illnesses caused by the external environment (e.g., massage to cure *empacho* [a ball of food clinging to stomach wall], wearing of talismans or charms for protection against illness)?
Cultural healers	Does patient rely on cultural healers (e.g. medicine men, Curandero, Chinese herbalist, hougan [voodoo priest], spiritualist, minister)?
Nutritional variables or factors	What nutritional variables or factors are influenced by the patient's ethnic/cultural background?

Characteristics of food preparation and consumption	What types of food preferences and restrictions, meanings of foods, style of food preparation and consumption, frequency of eating, time of eating, and eating utensils are culturally determined for patient? Are there any religious influences on food preparation and consumption?
Influences from external environment	What modifications, if any, did the patients' ethnic group make in its food practices in white dominant American society? Are there any adaptations of food customs and beliefs from rural setting to urban setting?
Patient education needs	What are some implications of diet planning and teaching to patient who adheres to cultural practices concerning foods?
SOCIOLOGICAL	
Economic status	Who is principal wage earner in patient's family? What is total annual income (approximately) of family? What impact does economic status have on life-style, place of residence, living conditions, and ability to obtain health services?
Educational status	What is highest educational level obtained? Does patient's educational background influence his ability to understand how to seek health services, literature on health care, patient teaching experiences, and any written material patient is exposed to in health care setting (e.g., admission forms, patient care forms, teaching literature, and lab test forms)?
	Does patient's educational background cause him to feel inferior or superior to health care personnel in health care setting?
Social network	What are patient's social networks (kinship, peer, cultural healing networks)? How do they influence health or illness status of patient?

Family as supportive group	Does patient's family feel need for continuous presence in patient's clinical setting (is this an ethnic/cultural characteristic)? How is family valued during illness or death?
	How does family participate in patient's nursing care process (e.g., giving baths, feeding, using touch as support [cultural meaning], supportive presence)?
	How does ethnic/cultural family structure influence patient response to health or illness (e.g., roles, beliefs, strengths, weaknesses, and social class)?
	Are there any key family roles characteristic of a specific ethnic/cultural group (e.g., grandmother in some black and American Indian families), and can these key persons be a resource for health personnel?
	What role does family play in health promotion or cause of illness (e.g., would family be intermediary group in patient interactions with health personnel and make decisions regarding his care)?
Supportive institutions in ethnic/cultural community	What influence do ethnic/cultural institutions have on patient receiving health services (i.e., institutions such as Organization of Migrant Workers, NAACP, Black Political Caucus, churches, schools, Urban League, community clinics)?
Institutional racism	How does institutional racism in health facilities influence patient's response to receiving health care?
PSYCHOLOGICAL	
Self-concept (identify)	Does patient show strong racial/cultural identity? How does this compare to that of other racial/cultural groups or to members of dominant society?
	What factors in patient's development helped to shape his self-concept (e.g., family, peers,

	society labels, external environment, institutions, racism)?
	How does patient deal with stereotypical behavior from health professionals?
	What is impact of racism on patient from distinct ethnic/cultural group (e.g., social anxiety, noncompliance to health care process in clinical settings, avoidance of utilizing or participating in health care institutions)?
	Does ethnic/cultural background have impact on how patient relates to body image change resulting from illness or surgery (e.g., importance of appearance and role in cultural group)?
	Any adherence or identification with ethnic/cultural "group identity" (e.g., solidarity, "we" concept)?
Mental and behavioral processes and characteristics of ethnic/cultural group	How does patient relate to his external environment in clinical setting (e.g., fears, stress, and adaptive mechanisms characteristic of a specific ethnic/cultural group)? Any variations based on the life span?
	What is patient's ability to relate to persons outside of his ethnic/cultural group (health personnel)? Is he withdrawn, verbally or nonverbally expressive, negative or positive, feeling mentally or physically inferior or superior?
	How does patient deal with feelings of loss of dignity and respect in clinical setting?
Religious influences on psychological effects of health/illness	Does patient's religion have a strong impact on how he relates to health/illness influences or outcomes (e.g., death/chronic illness, cause and effect of illness, or adherence to nursing/medical practices)?
	Do religious beliefs, sacred practices, and talismans play a role in treatment of disease?

	What is role of significant religious persons during health/illness (e.g., ministers, priests, monks, imams)?
Psychological/ cultural response to stress and discomfort of illness	Based on ethnic/cultural background, does patient exhibit any variations in psychological response to pain or physical disability of disease processes?

BIOLOGICAL/PHYSIOLOGICAL
(consideration of *norms* for different ethnic/cultural groups)

Racial-anatomical characteristics	Does patient have any distinct racial characteristics (e.g., skin color, hair texture and color, color of mucous membranes)? Does patient have any variations in anatomical characteristics (e.g., body structure [height and weight] more prevalent for ethnic/cultural group, skeletal formation [pelvic shape, especially for obstetrical evaluation], facial shape and structure [nose, eye shape, facial contour], upper and lower extremities)?
	How do patient's racial and anatomical characteristics affect his self-concept and the way others relate to him?
	Does variation in racial-anatomical characteristics affect physical evaluations and physical care, skin assessment based on color, and variations in hair care and hygienic practices?
Growth and development patterns	Are there any distinct growth and development characteristics that vary with patient's ethnic/cultural background (e.g., bone density, fatfolds, motor ability)? What factors are important for nutritional assessment, neurological and motor assessment, assessment of bone deterioration in disease process or injury, evaluation of newborns, evaluation of intellectual status or capacity, assessment of sensory/ motor sensory development in children? How do these differ in ethnic/cultural groups?

Variations in body systems	Are there any variations in body systems particular to distinct ethnic/cultural group (e.g., gastrointestinal disturbance with lactose intolerance, nutritional intake of cultural foods causing adverse effects on gastrointestinal tract and fluid and electrolyte system, variations in chemical and hematological systems [certain blood types prevalent in particular ethnic/cultural groups])?
Skin and hair physiology, mucous membranes	How does skin color variation influence assessment of skin color changes (e.g., jaundice, cyanosis, ecchymosis, erythema, and its relationship to disease processes)?
	What are methods of assessing skin color changes (comparing variations and similarities between different ethnic groups)?
	Are there conditions of hypopigmentation and hyperpigmentation (e.g., vitiligo, mongolian spots, albinism, discoloration caused by trauma)? Why would these be more striking in some ethnic groups?
	Are there any skin conditions more prevalent in a distinct ethnic group (e.g., keloids in blacks)?
	Is there any correlation between oral and skin pigmentation and their variations among distinct racial groups when doing assessment of oral cavity (e.g., leukoedema is normal occurrence in blacks)?
	What are variations in hair texture and color among racially different groups? Ask patient about preferred hair care methods or any racial/cultural restrictions (e.g., not washing "hot-combed" hair while in clinical setting, not cutting very long hair of Raza/Latina patients).
	Are there any variations in skin care methods (e.g., using Vaseline on black skin)?

Diseases more prevalent among ethnic/cultural group	Are there any specific diseases or conditions that are more prevalent for a specific ethnic/ cultural group (e.g., hypertension, sickle cell anemia, G6-PD, lactose intolerance)?
	Does patient have any socioenvironmental diseases common among ethnic/cultural groups (e.g., lead paint poisoning, poor nutrition, over-crowding; alcoholism resulting from psychological despair and alienation from dominant society, rat bites, poor sanitation)?
Diseases ethnic/ cultural group has increased resistance to	Are there any diseases that patient has increased resistance to because of racial/cultural background (e.g., skin cancer in blacks)?

Organizations Serving Culturally Diverse Communities

ALIANZA
3020 14th Street, N.W.
Fourth Floor
Washington, DC 20009
(202) 223-9600

ASIAN AMERICAN PSYCHOLOGICAL ASSOCIATION
16591 Melville Circle
Huntington Beach, CA 92649
(213) 592-3227

ASIAN AMERICAN COMMUNITY MENTAL HEALTH TRAINING CENTER
1300 W. Olympic Boulevard, #303
Los Angeles, CA
(213) 385-1474

ASSOCIATION OF AMERICAN INDIAN AFFAIRS, INC.
432 Park Avenue South
New York, NY 10016
(212) 689-8720

ASSOCIATION OF ASIAN/PACIFIC COMMUNITY HEALTH ORGANIZATIONS
310 8th Street, Suite 210
Oakland, CA 94607
(415) 272-9536

BEBASHI (Blacks Educating Blacks About Sexual Health Issues)
1319 Locust Street
Philadelphia, PA 19107
(215) 546-4140

COMMUNITY OUTREACH RISK REDUCTION EDUCATION PROGRAM (CORE)
6570 Santa Monica Boulevard
Los Angeles, CA 90038
(213) 460-4444

COSSMHO
Coalition of Hispanic Health and Human Service Organizations
1030 15th Street, N.W.
Washington, DC 20005
(202) 371-2100

HEALTH EDUCATION RESOURCE ORGANIZATION (HERO)
101 West Read Street, Suite 812
Baltimore, MD 21201
(301) 685-1180

JAPANESE AMERICAN CITIZENS LEAGUE
National Headquarters
1765 Sutter Street
San Francisco, CA 94115
(415) 921-5225

1730 Rhode Island Avenue, N.W., #204
Washington, DC 20036
(202) 223-1240

THE KUPONA NETWORK
4611 South Ellis Avenue
Chicago, IL 60653
(312) 536-3000

MULTICULTURAL PREVENTION RESOURCE CENTER (MPRC)
1540 Market Street, Suite 320
San Francisco, CA 94102
(415) 861-2142

NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE (NAACP)
1790 Broadway
New York, NY 10019
(212) 245-2100

NATIONAL ASSOCIATION FOR BLACK PSYCHOLOGISTS
1125 Spring Road, N.W.
Washington, DC 20010
(202) 576-7184

NATIONAL ASSOCIATION OF BLACK SOCIAL WORKERS (NABSW)
2008 Madison Avenue
New York, NY 10035
(212) 369-0639

NATIONAL BLACK WOMEN'S HEALTH PROJECT
1217 Gordon Street, S.W.
Atlanta, GA 30810
(404) 753-0916

NATIONAL CENTER FOR URBAN ETHNIC AFFAIRS
1521 16th Street, N.W.
Washington, DC 20036
(202) 232-3600

NATIONAL CONFERENCE OF PUERTO RICAN WOMEN
P. O. Box 4804
Washington, DC 20012

NATIONAL CONGRESS ON AMERICAN INDIANS/NCAI FUND
1430 K Street, N.W., Suite 700
Washington DC 20005
(202) 347-9520

NATIONAL COUNCIL OF LA RAZA
810 First Street, N.E.
Suite 300
Washington, DC 20002
(202) 289-1380

NATIONAL INSTITUTE OF MENTAL HEALTH
5600 Fishers Lane
Rockville, MD 20857
(301) 443-3533

NATIONAL URBAN LEAGUE
500 E. 62 Street
New York, NY 10021
(212) 310-9000

Research Department, NUL
733 15th Street, N.W.
Washington, DC 20005
(202) 783-0220

OFFICE OF LATINO AFFAIRS
2000 14th Street, N.W., 2nd Floor
Washington, DC 20009
(202) 939-8765

OFFICE OF MINORITY AFFAIRS
1012 14th Street, N.W., Suite 601
Washington, DC 20005
(202) 347-0390

OFFICE OF MINORITY HEALTH
Dept. of Health & Human Services
200 Independence Avenue, S.W.,
Room 118F
Washington, DC 20201
(202) 245-0020

OFFICE OF MINORITY HEALTH -- RESOURCE CENTER
P. O. Box 37337
Washington, DC 20013-7337
(301) 587-1938

- -- Maintains a computerized data base of minority health-related resources at local, state, and national levels.
- -- Coordinates resource persons network to provide technical assistance.